

# EFFECTS OF GENDER DIFFERENCES ON PHYSICIAN-ASSISTED SUICIDE: PRACTICE AND REGULATION

CYNTHIA A. PRADO\*

Many feminist critics of bioethics claim that bioethical discussions are almost always conducted with an androgynous patient in mind—rather, gender is out of mind. Professor of Law and Medicine, Susan M. Wolf describes this discussion as a focus on the “genderless generic patient.”<sup>1</sup> Although discussions of genetic research, organ transplantation and euthanasia are extensive, they lack sufficient attention to gender issues and gender implications.<sup>2</sup> When discussion does include attention to gender issues, it is usually in the bioethics area of reproduction. Although there may be faultless reasons for this insufficient attention to gender, it is nevertheless inappropriate and possibly harmful to both women and men. An area where this insufficiency is especially inappropriate and possibly harmful for women is the discussion of medical decisions at the end of life (MDEL), particularly physician-assisted suicide.<sup>3</sup> For example, consider that the majority of

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\* J.D. candidate, University of Southern California Law School, 1999; B.A. Psychology, Minor Bioethics, University of Southern California, 1996. I am grateful to Professor of Law, Michael H. Shapiro and to the 1998-99 Board and Staff of the Southern California Review of Law and Women’s Studies for their guidance in the production of this Article. I wish to express my heartfelt thanks to Natalie Prado and the rest of my family, Christopher M. Guyer and Donica Patel for their endless support throughout my law school experience. I also wish to acknowledge the gracious support of attorneys Suzanne J. Holland and Raymond W. Thomas.

1. Susan M. Wolf, *Shifting Paradigms in Bioethics and Health Law: The Rise of a New Pragmatism*, 20 AM. J.L. & MED. 395, 402, 405 (1994) [hereinafter Wolf, *Shifting Paradigms*]. See Susan M. Wolf, *Introduction: Gender and Feminism in Bioethics*, in FEMINISM & BIOETHICS: BEYOND REPRODUCTION 4-14 (Susan M. Wolf ed., 1996)[hereinafter Wolf, *Gender and Feminism*].

2. I encountered this lack of sufficient attention in my own initial search to find a gender issue within bioethics for this Article. Susan M. Wolf discusses this extensively and offers possible explanations in the introductory chapter of her book entitled *Feminism & Bioethics: Beyond Reproduction*. See Wolf, *Gender and Feminism*, *supra* note 1, at 3-33. This book is the most valuable source of literature that explores gender issues in all the areas of bioethics. It was also invaluable to me in writing this Article, serving as a starting point to my research.

3. MDEL also include the withholding and termination of life-sustaining or life-saving care, and involuntary and voluntary euthanasia. I do not imply that the only inappropriate and

known patients involved in physician-assisted suicides are women.<sup>4</sup> As discussion progresses and legal developments in the United States regarding physician-assisted suicide continue, analysis with attention to gender issues and gender implications in this area is needed and long overdue. This Article will focus on the particular MDEL of physician-assisted suicide.<sup>5</sup> Part one will present background information concerning physician-assisted suicide and its minimal recent discussions of gender.

The fact that the majority of known and publicized physician-assisted suicides involve women has led to a belief that the practice of euthanasia and physician-assisted suicide will cause (or has caused already) negative and disproportionate effects on women in the United States.<sup>6</sup> Such effects include more women than men requesting physician-assisted suicide, more women's requests being granted and thus, more women dying. Many feminists argue that these effects may be so significant and so harmful to women that physician-assisted suicide should not be legalized or practiced.<sup>7</sup> Among these feminists is Professor Wolf. Wolf argues that gender differences in socialization and gender roles, suicidal behavior, factors of depression, life expectancy and illness, health care access and quality and the physician-patient relationship may make women, more than men, susceptible to requesting physician-assisted suicide and possibly make physicians

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possibly harmful MDEL lacking sufficient attention is physician-assisted suicide. Rather, for purposes of this Article, I chose to only focus on physician-assisted suicide.

4. See Nancy J. Osgood & Susan A. Eisenhandler, *Gender and Assisted and Acquiescent Suicide: A Suicidologist's Perspective*, 9 ISSUES L. & MED. 361, 364 (1994).

5. I focus on physician-assisted suicide mainly due to the fact that it is now legal in the state of Oregon. Moreover, if and when other states follow Oregon, physician-assisted suicide will be the likely legalized practice, as opposed to the more controversial practice of euthanasia.

6. See Susan M. Wolf, *Gender, Feminism, and Death: Physician-Assisted Suicide and Euthanasia*, in FEMINISM & BIOETHICS: BEYOND REPRODUCTION 282-308 (Susan M. Wolf ed., 1996) [hereinafter Wolf, *Gender, Feminism, and Death*]. Wolf presents this growing belief, yet also acknowledges that this belief cannot be tested because of the lack of systemic data in the United States. See *id.* at 283, 288. She goes on to propose the need for more research and consequently, opposes the legalization of physician-assisted suicide. See *id.* at 286.

7. See *id.* at 282-308. But see Jocelyn Downie and Susan Sherwin, *A Feminists Exploration of Issues Around Assisted Death*, 15 ST. LOUIS U. PUB. L. REV. 303 (1996) (supporting a limited permissive legislative policy for physician-assisted suicide with the same respect for autonomy principle that permits abortions). I do not propose that if women want and request physician-assisted suicide, and their autonomy is not compromised, the request should not be granted. Rather, because the many real and present gender differences and inequalities in the United States may compromise autonomy, the granting of women's requests may require greater scrutiny.

more susceptible to granting the requests.<sup>8</sup> In part two of this Article, evidence that these gender differences may contribute to the negative and disproportionate effects on women in the practice of physician-assisted suicide is discussed. I agree that many of the gender differences will contribute to such effects on women in that there may be more requests and grants of requests for physician-assisted suicide made by women than men. I refer to this as the under-protection of women. However, I believe that gender differences will also contribute to negative and disproportionate effects in another direction; more requests by women than men for physician-assisted suicide may be inappropriately refused or unfairly dismissed by physicians. I refer to this as the over-protection of women. Therefore, negative and disproportionate effects can run in two different directions—under-protecting and over-protecting women. The manifestations of the under-protection and over-protection of women in the context of physician-assisted suicide will also be discussed in part two.

In view of the growing support and legalization of physician-assisted suicide, I do not discuss whether it should be legalized or practiced. Rather, I propose an approach to deal with these gender differences in order to minimize or prevent both the under-protection and over-protection of women. Two approaches to the practice of physician-assisted suicide will be examined in part three of this Article. The first is the Netherlands quasi-legislation approach of euthanasia and physician-assisted suicide.<sup>9</sup> I will show how the unique Dutch culture affects the practice of physician-assisted suicide, and how the quasi-legislation approach succeeds and fails to prevent negative and disproportionate effects on women. The second is the world's first statute that affirmatively legalized physician-assisted suicide. This statute is the Death with Dignity Act, enacted within the United States in the state of Oregon in 1997.<sup>10</sup> I will show how this statutory

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8. See Wolf, *Gender, Feminism, and Death*, *supra* note 6, at 287-97; Susan M. Wolf, *Physician-Assisted Suicide, Abortion, and Treatment Refusal*, in *PHYSICIAN-ASSISTED SUICIDE* (Robert F. Weir ed., 1997). For a discussion on race differences within bioethics, see Wolf, *Shifting Paradigms*, *supra* note 1, at 406-08.

9. I limit my examination to the Netherlands because of its history and practice of euthanasia and physician-assisted suicide that has resulted in much data and many studies about MDEL practices. For an international review of MDEL practices, see James L. Underwood, *The Supreme Court's Assisted Suicide Opinions in International Perspective: Avoiding a Bureaucracy of Death*, 73 N.D. L. REV. 641 (1997).

10. OR. REV. STAT. tit.13, ch. 127.800-127.995 (1997).

approach also succeeds and fails to prevent negative and disproportionate effects on women from the practice of physician-assisted suicide. After examining the Netherlands and Oregon approaches, I conclude that the more appropriate approach to the practice of physician-assisted suicide in the United States is one of detailed and strict regulation through statute.

In part four of this Article, guidelines and suggestions for the detailed and strict regulation are proposed. My goal with these guidelines and suggestions is to minimize or prevent the gender differences discussed in part two from contributing to negative and disproportionate effects on women in the practice of physician-assisted suicide.

## I. PHYSICIAN-ASSISTED SUICIDE: BACKGROUND AND ISSUE OF GENDER

American legal and philosophical movements regarding an individual's right to die have always been profound and strong. MDEL legislation, specifically regarding euthanasia and physician-assisted suicide, is constantly being proposed in the United States. The first piece of such legislation was introduced in 1906.<sup>11</sup> The strong devotion to the Western philosophy of self-determination and autonomy was clearly demonstrated by Judge Cardozo in 1914 when he wrote that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body."<sup>12</sup> Although the United States has a long history of common law and proposals of legislation supporting this philosophy, only within the last decade has passing legislation legalizing physician-assisted suicide been likely. This is due to the growing support for the practice of physician-assisted suicide.<sup>13</sup> Moreover, passage of legislation has actually occurred in the last two years with the enactment of the Oregon Death with Dignity Act. It is the world's first statute affirmatively legalizing the practice of physician-assisted suicide.<sup>14</sup> In view of the

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11. See Judith F. Daar, *Direct Democracy and Bioethical Choices: Voting Life and Death at the Ballot Box*, 28 U. MICH. J.L. REFORM 799, 816-24 (1995).

12. *Scholendorff v. Society of N.Y. Hosp.*, 105 N.E. 92, 93 (1914). Although this case has been overruled and superseded in part, Cardozo's proposition remains valid and is continuously cited in current case law.

13. See Leslie Berkman, *O.C. in Middle of 'Death with Dignity' Debate*, L.A. TIMES, Oct. 4, 1992, at A1 (reporting a Gallup poll showing 34% of Americans supported physician-assisted suicide in 1950, whereas the percentage increased to 65% in 1990). *But see* National Desk, L.A. TIMES, Nov. 3, 1998, at A16 (reporting voter rejection of a Michigan measure that would legalize physician-assisted suicide).

14. See *infra* text accompanying notes 192-207.

obvious growing support for the legalization and practice of physician-assisted suicide, discussion on how it should be regulated may take priority over moral and philosophical discussions.

In all practices in areas of life—familial, cultural, educational, vocational, legal and medical—there will always be risk of abuses, as well as people who are more vulnerable than others to such abuses. In the practice of physician-assisted suicide, the least powerful groups of people in the United States are generally the most vulnerable to the risk of abuses. These groups include women, minorities, the elderly and the poor, all of whom are mostly aware of their vulnerability. This is evidenced by their lack of support for the legalization of physician-assisted suicide.<sup>15</sup> Regarding gender, most surveys and polls show that women consistently oppose euthanasia and physician-assisted suicide practices more than men.<sup>16</sup> Members of all these groups are also more likely to request such practices for the many different reasons discussed in part two of this Article.

The recent, albeit insufficient, focus on gender in MDEL discussions has been triggered by a recognition of gender patterns, specifically the disproportionate involvement of women. To begin, the practice of physician-assisted suicide is most widely known to Americans by the media publicity of the infamous Michigan physician, Dr. Kevorkian. From the media presentation, most of his assistees<sup>17</sup> have

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15. In a 1992 poll taken by the Associated Press, 69% of the respondents ages 18-34 expressed support for physician-assisted suicide, but less than half of the respondents over age 65 expressed support. See David Briggs, *High-Tech Medicine Offers the Illusion of Immortality*, RECORD, Dec. 20, 1992, at A50. The results from the vote of California's Proposition 161 in 1993 showed females opposed it 56% to 44%, white males were split at 50% to 50%, whites opposed it 52% to 48%, and blacks and Hispanics opposed it 60% to 40%. See Alexander Morgan Capron, *Even in Defeat, Proposition 161 Sounds a Warning*, HASTINGS CENTER REP., Jan.-Feb. 1993, at 32. In a later 1996 poll, 54% of men favored the legalization of physician-assisted suicide contrasted to only 47% of women. See MARILYN WEBB, *THE GOOD DEATH* 393 (1997). See also Wolf, *Gender, Feminism, and Death*, *supra* note 6, at 290 (citing to evidence that women, Asian and African Americans, the elderly and men of a particular age and income level were the groups that least supported the legalization of active euthanasia). However, in a 1997 survey reported by *Florida Today*, 51% of women favored legalization of physician-assisted suicide whereas only 44% of men favored it. See Rita Elkins, *Death Debate*, FLORIDA TODAY, June 1, 1997, at 1D. Additionally, a survey of oncology patients did not find gender "to be significantly associated with attitudes or actions relating to euthanasia or physician-assisted suicide." Ezekiel J. Emanuel, Diane L. Fairclough, Elisabeth R. Daniels, & Brian R. Clarridge, *Fair Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists, and the Public*, 347 LANCET 1805 (1996)[hereinafter Emanuel, *Attitudes and Experience*].

16. See the discussion of polls and surveys, *supra* note 15 and accompanying text.

17. I purposely refrain from referring to Dr. Kevorkian's assistees as patients because, in many cases, he fails to establish a physician-patient relationship. See *infra* text accompanying notes 98-135, 153-55 (discussing physician-patient relationships).

been middle-aged women.<sup>18</sup> Thus, many critics of Kevorkian have depicted his practice of physician-assisted suicide as gender-biased.<sup>19</sup> One critic has even described his practice as “womanslaughter.”<sup>20</sup> If Kevorkian’s assisted suicides are viewed as typical of the requests and grants of all physician-assisted suicides, then it may be expected that the practice of physician-assisted suicide will disproportionately involve women. However, this expectation may not be correct in view of the fact that the total number of Kevorkian’s assistees has been grossly underestimated. Kevorkian claims to have assisted between 70 and 100 people in ending their lives, and states that he receives two to three requests a day for his assistance.<sup>21</sup> It is also reported that “[n]early half of the requests are from men” which may further discredit any finding or expectation of a gender pattern.<sup>22</sup> Therefore, in order to extrapolate from Kevorkian’s physician-assisted suicide practice to that of broader society, accurate gender proportions of Kevorkian’s potential and actual assistees must be obtained.

A second recognized gender pattern that has triggered a focus on gender issues in MDEL are legal developments arising through case law. New precedents regarding MDEL in both American and Dutch law have primarily involved women.<sup>23</sup> In the United States, precedents were created by the cases of *Elizabeth Bouvia*,<sup>24</sup> *Karen Ann*

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18. See Silvia Sara Canetto, *Elderly, Women and Suicidal Behavior*, in *WOMEN AND SUICIDAL BEHAVIOR* 228 (Silvia Sara Canetto & David Lester eds., 1995) (citing a 1993 study analyzing 20 of Kevorkian’s assisted suicides, finding that 60% involved women and 67% of the women were in their 40s and 50s).

19. See B.D. Colen, *Gender Question in Assisted Suicides*, *NEWSDAY*, Nov. 25, 1992, at 17; Ellen Goodman, *Act Now to Stop Dr. Death*, *ATLANTA CONSTITUTION*, May 27, 1992, at A11.

20. Goodman, *supra* note 19, at A11.

21. See Ann Hodges, *HBO Special Examines Dr. Death*, *HOUS. CHRON.*, Nov. 4, 1997, at 4. According to the International Anti-Euthanasia Task Force, Kevorkian has assisted 110 people commit suicide. Of the female identifiable names, 64 were women, making them 69% of the total. See International Anti-Euthanasia Task Force, *Kevorkian’s Known Victims* (visited Nov. 23, 1998) <<http://www.laetf.org/kevv.htm>>.

22. *Id.* Dr. Kevorkian also states that “[w]omen seem to take things in stride more.” *Id.* This may be contradictory because if this were true, the majority of requests would then be from men. However, it is possible that Kevorkian sees a request for physician-assisted suicide as the more courageous alternative.

23. See HERBERT HENDIN, *SEDUCED BY DEATH: DOCTORS, PATIENTS, AND THE DUTCH CURE* 50 (1997) [hereinafter HENDIN, *SEDUCED BY DEATH*]; Steven H. Miles & Allison August, *Courts, Gender and “The Right to Die,”* 18 *L. MED. & HEALTH CARE* 85 (1990).

24. *Bouvia v. Superior Court*, 225 Cal. Rptr. 297 (Ct. App. 1986) (finding a competent patient has an exclusive right to refuse any medical treatment or service, even if life-saving or life-prolonging).

*Quinlan*<sup>25</sup> and *Nancy Cruzan*.<sup>26</sup> In the Netherlands, recent legal developments have involved the highly controversial case of *Chabot*.<sup>27</sup> This case law pattern and Kevorkian's pattern may or may not be an accurate depiction of the current and future practice of physician-assisted suicide. Nevertheless, the patterns have triggered needed and long overdue discussion of gender issues and gender implications in this area of bioethics.

## II. GENDER DIFFERENCES AND DISPARITIES CONTRIBUTING TO NEGATIVE AND DISPROPORTIONATE EFFECTS

Gender differences affect the practice of physician-assisted suicide by under-protecting women (thereby increasing the incidences of physician-assisted suicides of women) and also by over-protecting women (thereby decreasing the incidences of physician-assisted suicides of women). The two interests here are the protection of women's lives and the ability to exercise their autonomy. By over-protecting life, under-protecting autonomy may occur, and by over-protecting autonomy, under-protecting life may occur. Both ways have negative and disproportionate effects on women. However, these effects can be minimized or prevented through the awareness of gender differences and disparities, and with attempts to change them. I present six major areas of gender differences as contributing causes for these effects: socialization and gender roles, suicidal behavior, depression and mental illness, life expectancy and illness, health care access and quality, and the physician-patient relationship.

### A. SOCIALIZATION AND GENDER ROLES

The traditional role of women is a significant factor affecting the practice of physician-assisted suicide that may contribute to the under-protection of women. Some believe that the way women are traditionally socialized makes or will make women, more than men, request physician-assisted suicide for the wrong reasons. Women are traditionally socialized to be the "keepers of the family nest," caregivers and self-sacrificers who are always expected to put the

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25. *In re Quinlan*, 355 A.2d 647 (1976) (finding the right to privacy is sufficiently broad to include a patient's decision to decline medical treatment).

26. *Cruzan v. Missouri Dep't of Health*, 497 U.S. 261 (1990) (holding that a competent person has a constitutionally protected right to refuse unwanted medical treatment).

27. Gene Kaufmann, Case Note, *State v. Chabot: A Euthanasia Case from the Netherlands*, 20 OHIO N.U. L. REV. 815, 816-17 (1994).

needs of others before their own.<sup>28</sup> However, this role changes when women grow older and become ill. Women are then placed in the role of receiving care. This recipient role is contrary to women's socialized personality and beliefs, and contrary to society's traditional gender roles. Because women refuse or are unable to accept this different role, they are more likely than men to request physician-assisted suicide or more susceptible to its suggestion.<sup>29</sup> Thus, physician-assisted suicide may be viewed by women as a way of fulfilling and furthering their traditional role as self-sacrificer by ending their life to relieve their family and friends of financial, physical and emotional burden.<sup>30</sup> The fear of being a burden to family and friends is a frequently offered reason in support of physician-assisted suicide. In fact, among Americans who would consider physician-assisted suicide, 47% reported fear of being a burden to their families as a reason for their decision, and 60% reported fear of being a financial burden to their children.<sup>31</sup> Similarly, in a 1996 Gallup poll, 40% of respondents reported that they would accelerate their death to prevent being a burden to others.<sup>32</sup> Although these statistics are not divided by gender, they are strong indicators that American women are likely to feel financially and emotionally pressured to consider and request physician-assisted suicide, thus making it a questionable autonomous decision.<sup>33</sup>

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28. Elkins, *supra* note 15, at 1D. See CAROL GILLIGAN, *IN A DIFFERENT VOICE: PSYCHOLOGICAL THEORY AND WOMEN'S DEVELOPMENT* 64-105 (1982); Barbara Dority, *The Ultimate Civil Liberty*, 57 HUMANIST 16 (1997); Barbara Welter, *The Cult of True Womanhood: 1820-1860*, 18 AM. QUARTERLY 151, 163-64 (1966).

29. See Alexander Morgan Capron & Vicki Michel, *Be Sure to Read the Fine Print: Will California Legalize Euthanasia*, COMMONWEAL, Sept. 25, 1992, at 16.

30. However, Webb claims that the traditional caregivers who are usually women, become "tyrannizing patients" making unreasonable demands on family members causing their family to feel anger and guilt. WEBB, *supra* note 15, at 212. Additionally, one study has found that seriously physically ill women want to continue living at least as long as men, even if they are completely dependent on family and friends for their care. However, it must be noted that this study took place under conditions where euthanasia and physician-assisted suicide were illegal. See Lawrence J. Schneiderman, Richard Kronick, Robert M. Kaplan, John P. Anderson & Robert D. Langer, *Attitudes of Seriously Ill Patients Toward Treatment that Involves High Costs and Burdens on Others*, 5 J. CLINICAL ETHICS 109, 111 (1994).

31. See Robert J. Blendon, Ulrike S. Szalay & Richard A. Knox, *Should Physicians Aid Their Patients in Dying? The Public Perspective*, 267 JAMA 2658, 2660 (1992).

32. See Anita Silvers, *Protecting the Innocents*, 166 W. J. MED 407, 408 (1997) (citing to a Gallup poll conducted on October 3, 1996). This statistic is interesting in comparison to reported reasons given by patients in the Netherlands to justify the practice of physician-assisted suicide. See *infra* text accompanying notes 147-52.

33. However, it is argued that "the fact that an individual is concerned with the well-being of others is not evidence that she is not acting voluntarily." Downie & Sherwin, *supra* note 7, at 321-22.

Sexism and ageism in the United States may also contribute to women's vulnerability to request and susceptibility to the suggestion of physician-assisted suicide. In fact, some in society have a "view that sick women are disposable."<sup>34</sup> Many older women, who are more likely than men to be victims of sexism and ageism, experience self-derogation and feelings of dejection, degradation, devaluation, uselessness and worthlessness.<sup>35</sup> It may be expected then, that older women with these forced experiences and feelings, in addition to physical illness, mental deterioration and fears of becoming a burden to others, will more likely than men consider and request physician-assisted suicide.<sup>36</sup> Again, this may not be a genuinely autonomous decision. Thus, the negative and disproportionate effect from socialization and gender roles is an under-protection of women by their increased involvement in physician-assisted suicide.

## B. SUICIDAL BEHAVIOR

Gender differences in suicidal behavior significantly contribute to negative and disproportionate effects on women from the practice of physician-assisted suicide. Women attempt suicide more often than men, although men actually commit more suicides than women.<sup>37</sup> Thus, women are considered the "attempters" and men the "committers."<sup>38</sup> However, when incidences of all attempted and committed suicides are totaled, the number of women still exceed men in the desire to end their lives.<sup>39</sup> This number may be even greater; since women are mostly attempters of suicide, it is likely that such suicide attempts by women are underreported.<sup>40</sup>

The attempter and committer difference is said to be caused by the usual techniques of suicide employed by women and men. Men usually employ lethal and violent methods of suicide, such as via guns

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34. Elkins, *supra* note 15, at 1D.

35. See Osgood & Eisenhandler, *supra* note 4, at 365.

36. See *id.*

37. See CHARLES NEURINGER & DAN J. LETTIERI, *SUICIDAL WOMEN: THEIR THINKING AND FEELING PATTERNS* vii (1982).

38. Wolf, *Gender, Feminism and Death*, *supra* note 6, at 284.

39. See RAYMOND JACK, *WOMEN AND ATTEMPTED SUICIDE* 31 (1992). However, this is somewhat contradictory to studies that show women are less accepting of suicidal death than men. See Canetto, *supra* note 18, at 226. This may be because women are judging other's actions as opposed to judging their own possible actions.

40. See Silvia Sara Canetto, *Gender Issues in Counseling the Suicidal Elderly*, in *NOW I LAY ME DOWN: SUICIDE IN THE ELDERLY* 88, 89 (David Lester & Margot Tallmer eds., 1994) [hereinafter Canetto, *Counseling the Suicidal Elderly*].

or hangings, which increase the likelihood of death; women, however, usually employ less lethal and violent methods of suicide such as self-poisoning or suffocation.<sup>41</sup> The difference in techniques may be representative of a difference of certainty in the desire to end life. A man's suicide attempt may be a more unequivocal desire to die, whereas a woman's suicide attempt may more likely be a symbolic call for help from family and friends. It may then be reasonable to believe that this gender difference increases the likelihood that more women, who probably would have only been attempters of suicide, will become committers if they receive physician assistance. This would result in the under-protection of women. Yet, this belief may not be completely accurate. For example, if women chose the less lethal techniques for suicide because of their uncertainty in the desire to end their lives, the uncertainty will likely preclude women from requesting the almost inevitably lethal technique of physician-assisted suicide.<sup>42</sup>

On a different note, there is evidence that society is more accepting of suicides by older women, so long as they are assisted by a physician.<sup>43</sup> Similarly, society is generally more accepting of suicides by women than by men.<sup>44</sup> This greater societal acceptance may then contribute to women feeling less inhibited to consider and request physician-assisted suicide. Thus, these negative and disproportionate effects result in an increased number of women involved in physician-assisted suicide which is an under-protection of women.

### C. DEPRESSION AND MENTAL ILLNESS

The gender difference in the incidence of depression is another significant factor that will contribute to negative and disproportionate effects on women in the practice of physician-assisted suicide. To begin, patients suffering from depression are more likely than those who are free from depression to consider and request aid-in-dying from their physicians.<sup>45</sup> Terminally ill patients who express an unequivocal desire to end their lives are likely to be clinically depressed,<sup>46</sup>

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41. See David Lester, *Suicide in the Elderly: An Overview*, in NOW I LAY ME DOWN: SUICIDE IN THE ELDERLY, *supra* note 40, at 13 (citing J.L. McIntosh & J.F. Santos, *Methods of Suicide by Age*, 22 INT'L J. AGING & HUM. DEV. 123-39, (1985-86)); NANCY J. OSGOOD, BARBARA A. BRANT & AARON LIPMAN, SUICIDE AMONG THE ELDERLY IN LONG-TERM CARE FACILITIES 3 (1991) (citing three different studies).

42. This may be a known or unknown uncertainty in a woman's desire to end her life.

43. See Canetto, *supra* note 18, at 229.

44. See *id.* at 228.

45. See Emanuel, Fairclough, Daniels & Clarridge, *supra* note 15, at 1805.

46. See Eric Chevlen, *The Limits of Prognostication*, 35 DUQ. L. REV. 337, 346-49 (1996).

which may be due to untreated pain.<sup>47</sup> Depressed patients are also more likely to be women in view of estimates that approximately twice as many women than men suffer from depression at any age.<sup>48</sup> In the older patient population, consisting mostly of women,<sup>49</sup> depression is the most common mental illness. Furthermore, studies have found that suffering from depression is the primary contributor of suicides among older patients who are also suffering physical illness.<sup>50</sup> The higher rate of depression in older women compared to older men has also been found to be caused by physical illness.<sup>51</sup>

Many reasons are offered to explain the greater incidences of depression in women than in men. First, women may be biologically and hormonally vulnerable to depression. Second, the socialization of women contributes to a learned helplessness disposition creating a susceptibility to depression.<sup>52</sup> Third, women more often experience greater pain than men, which is a significant contributor to depression.<sup>53</sup> Fourth, women, especially older women, are more likely than men to experience financial strain.<sup>54</sup> Because of this financial strain, older women are more likely than men forced to forego or discontinue treatment for depression. They are also less likely than men to have private insurance coverage,<sup>55</sup> where the treatment for depression is generally more substantial and of greater quality. Regarding the older population, "women and men enter old age with vastly different personal and social resources as a result of life course experiences within social structures influenced by gender."<sup>56</sup> Gender differences of

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47. See WEBB, *supra* note 15, at 114. It should be noted however, that not all academics and physicians agree on this point.

48. See William Coryell, Jean Endicott & Martin Keller, *Major Depression in a Nonclinical Sample: Demographic and Clinical Risk Factors for First Onset*, 49 ARCHIVES GEN. PSYCHIATRY 117, 117 (1992).

49. See *infra* text accompanying notes 63-66.

50. See OSGOOD, BRANT & LIPMAN, *supra* note 41, at 2, 4, 102-14. Other characteristics that contribute to vulnerability are age, race, marital status, illness, and psycho-social and environmental factors. See *id.* at 2-4.

51. See Canetto, *Counseling the Suicidal Elderly*, *supra* note 40, at 92.

52. See JACK, *supra* note 39, at 109, 129. However, with continuing movements to decrease gender discrimination and gender stereotypes, and increased education and employment of women, it may be likely that learned helplessness and thus, depression will also decrease. Attempting to verify this hypothesis is beyond the scope of this Article.

53. See *infra* text accompanying notes 64-76.

54. See Canetto, *supra* note 18, at 218-19.

55. See *id.* at 219.

56. Canetto, *Counseling the Suicidal Elderly*, *supra* note 40, at 101.

depression will obviously affect the practice of physician-assisted suicide.<sup>57</sup> Since women are more likely to suffer from depression and thus, more likely to request physician-assisted suicide, the expectation is the negative and disproportionate effect of under-protecting women.

However, this may not be a completely accurate expectation. It is generally known that women suffer from depression more than men. Many studies have found that women are also more likely to be diagnosed and treated for mental illnesses.<sup>58</sup> This is supported by the evidence that more women than men in the United States are prescribed and take psychotropic drugs and antidepressants.<sup>59</sup> Thus, it may be reasonable to expect physicians and psychiatrists to protect women "from themselves," which will be an over-protection of women. This over-protection could lead to an inaccurate determination that a woman is depressed and thus, not competent to make significant MDEL. Therefore, physicians may disproportionately refuse more legitimate requests made by women than men for physician-assisted suicide.

Yet, this over-protection argument may not be very persuasive. This is because the appropriate diagnosis of depression—clinical depression versus situation-appropriate depression—of seriously ill patients is very difficult to make and is often made inaccurately.<sup>60</sup> Also, research has found that primary care physicians fail to diagnose depression about half the time.<sup>61</sup> Therefore, this failure to diagnose

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57. Professor of Psychology, Silvia Sara Canetto concludes with the suggestion that counseling of suicidal elderly persons should include consideration of gender differences and similarities that women and men experience during their lifetimes. *See id.* at 100-01.

58. *See* JACK, *supra* note 39, at 108; SUSAN SHERWIN, *NO LONGER PATIENT* 152 (1992).

59. However, this does not necessarily mean that women actually suffer from mental illness more often than men. Possible reasons offered to explain this gender disparity are that women are more responsive to and expressive of their feelings of distress, men are more likely than women to be in occupations where the prescription of drugs would be harmful (such as machine operators or air traffic controllers), or physicians avoid prescribing drugs to patients who they suspect are alcoholics, who are more likely to be men. *See* Ann A. Hohmann, *Gender Bias in Psychotropic Drug Prescribing in Primary Care*, 27 *MED. CARE* 478-79, 488 (1989); BARBARA EHRENREICH & DEIRDRE ENGLISH, *FOR HER OWN GOOD: 150 YEARS OF THE EXPERTS' ADVICE TO WOMEN* 255 (1978); JACK, *supra* note 39, at 95-98; SHERWIN, *supra* note 58, at 152.

60. *See* Chevlen, *supra* note 46, at 346-49. Consider the argument that depression is a rational response to illness and pain, such that depression should not preclude the granting of a request for physician-assisted suicide. *See* Guy I. Benrubi, *Sounding Board: Euthanasia-The Need for Procedural Safeguards*, 326 *NEW ENG. J. MED.* 197, 198 (1992); Chevlen, *supra* note 46, at 346; WEBB, *supra* note 15, at 114-15.

61. *See* Melinda A. Lee, *The Oregon Death with Dignity Act: Implementation Issues*, 166 *W. J. MED.* 398, 400 (1997).

could contribute to the under-protection of women by the granting of illegitimate requests for physician-assisted suicide.<sup>62</sup>

#### D. LIFE EXPECTANCY AND PHYSICAL ILLNESS

The gender difference of life expectancy may also cause negative and disproportionate effects on women in the practice of physician-assisted suicide. The life expectancy for women is seven years greater than that of men.<sup>63</sup> Therefore, women make up the majority of the older population who become frail and physically ill. Consequently, “[w]omen have more incidents of physical illness and disability than men and are more likely than men to suffer from acute illnesses and non-fatal conditions . . . [that eventually] turn into chronic disabilities.”<sup>64</sup> Studies show that physical illness with pain is one, if not the most, predominate factor in all elderly suicides, with or without assistance.<sup>65</sup> This is evidenced by numerous studies finding that many elderly suffer from physical illness at the time of their suicide.<sup>66</sup> Therefore, if women make up most of the elderly population and are more likely than men to suffer from chronic physical illness with pain, they will be more susceptible to consider and request physician-assisted suicide. While this conclusion may be the result of generalizing all physical illnesses and pain, it is important to consider that different types of illness may affect women and men differently.<sup>67</sup> For example, a study in Denmark of 5,535 multiple sclerosis patients found that the suicide rate of men was twice the rate of the general population.<sup>68</sup> However, the suicide rate of women was lower at only 1.65 times greater than the rate of the general population.<sup>69</sup>

Gender differences in pain relief will also affect the practice of physician-assisted suicide. To begin, fear of pain and fear of possible inability to relieve intolerable pain are frequently offered reasons of supporters of physician-assisted suicide. There is overwhelming evidence that effective pain relief is not practiced in medicine, except

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62. Men may also be under-protected by this failure to diagnose depression.

63. See Canetto, *Counseling the Suicidal Elderly*, *supra* note 40, at 90.

64. *Id.* at 91.

65. See Sharon M. Valente & Judith M. Saunders, *Women, Physical Illness and Suicidal Behavior*, in *WOMEN AND SUICIDAL BEHAVIOR*, *supra* note 18, at 174-81.

66. See Lester, *supra* note 41, at 12.

67. See Valente & Saunders, *supra* note 65, at 179.

68. See Paul Novoselick, *Patients with MS Higher Risk for Suicide*, GRAND RAPIDS PRESS, Apr. 24, 1997, at D5.

69. See *id.* This study concluded that as multiple sclerosis progresses, the risk of suicide increases such that “more psycho-social support and treatment may be needed.” *Id.*

possibly in hospice care. Studies have shown that 25% of terminal cancer patients do not have effective pain relief compared with only 2% of hospice patients.<sup>70</sup> Thus, pain is either under-treated or neglected.<sup>71</sup> Additional studies show that the elderly, minorities, children and women are more likely to suffer from ineffective medical care and thus under-treated pain.<sup>72</sup> Pain is neglected due to its increased difficulty in accurate assessment when the patient is not of the same age, race, ethnic background or sex as the physician,<sup>73</sup> which occurs frequently since most physicians are men and most patients are women.<sup>74</sup> Therefore, if women are more likely to suffer from under-treated and neglected pain, it is reasonable to expect that they will be more susceptible to consider and request physician-assisted suicide in order to relieve their pain. This is a negative and disproportionate effect of an under-protection of women.

However, this under-protection of women may not be a fully accurate expectation considering the expressions of patients who are actually suffering from pain. For example, a study focusing on patients with cancer found that those actually suffering from pain were more likely, than those not suffering from pain, to believe that physician-assisted suicide was an unacceptable alternative.<sup>75</sup> Furthermore, the fears of pain and the possible inability to relieve intolerable pain may not be as great as widely believed. In a 1996 Gallup poll conducted for the National Hospice Association, only 14% of respondents reported that they would accelerate their death in order to escape intolerable pain.<sup>76</sup>

#### E. HEALTH CARE ACCESS AND QUALITY

Gender differences in health care access and quality will also affect the practice of physician-assisted suicide and will contribute to

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70. See Council on Scientific Affairs of the American Medical Association, *Good Care of the Dying Patient*, 275 JAMA 474, 475 (1996).

71. Pain may be under-treated because of fear of disciplinary actions or criminal proceedings for the illegal use of pain medication. See Lonnie R. Bristow, *Report of the Council Ethical and Judicial Affairs of the American Medical Association*, ISSUES L. & MED. 91, 94 (1994); Sandra Hanneken Johnson, *Removing Legal Constraints on Effective Pain Relief*, 5 BIOETHICS BULL., Winter-Spring 1997, at 9-10.

72. See Charles S. Cleeland et al., *Pain and Its Treatment in Outpatients with Metastatic Cancer*, 330 NEW ENG. J. MED. 592, 595; Johnson, *supra* note 71, at 1.

73. See Cleeland et al., *supra* note 72, at 592, 595.

74. See *infra* text accompanying notes 102-06.

75. See Emanuel, *Attitudes and Experiences*, *supra* note 15, at 1805.

76. See Silvers, *supra* note 32, at 408. Forty percent of respondents also reported they would accelerate their death to prevent becoming a burden to others. See *id.*

negative and disproportionate effects of under-protections of women. To begin, problems in health care access are widespread in the United States. Tens of millions of Americans lack access to adequate health care<sup>77</sup> – these Americans are more likely to be women.<sup>78</sup> Therefore, it is reasonable to expect that more women than men suffer from physical illness and pain due to insufficient access and quality health care. Pain is also more likely experienced by women and to a greater degree, due to inadequate palliative and hospice care services. Thus, women will be more susceptible to consider and request physician-assisted suicide.

At first glance, it may not seem that health care access for women is a significant problem affecting important MDEL. For example, studies have found that women visit physicians more than men, are hospitalized more often than men and receive more tests and medical services than men.<sup>79</sup> However, studies also show that women are generally less likely than men to receive quality health care for illnesses.<sup>80</sup> There may be many reasons for this. First, consider the correlation between socioeconomic status and health—the lower the socioeconomic status of a woman, the poorer her health.<sup>81</sup> Women, who are more likely to be poor than men,<sup>82</sup> depend more on government programs for their health care.<sup>83</sup> Men are more likely to have private insurance coverage plans<sup>84</sup> which provide greater access to and a higher quality of health care than do government health care programs. Additionally, statistics show that older women who are disabled and ill are at higher risk than similarly situated men of being institutionalized.<sup>85</sup> In these institutionalized settings, the quality of health care is generally lower. Not surprisingly, disabled men are more likely to be cared for by their wives than are disabled women

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77. See Yale Kamisar, *Why So Many People Support Physician-Assisted Suicide*, L. QUADRANGLE NOTES, Fall-Winter 1996, at 84, 88.

78. See Wolf, *Gender, Feminism, and Death*, *supra* note 6, at 290-91.

79. See Council on Ethical and Judicial Affairs of the American Medical Association, *Gender Disparities in Clinical Decision Making*, 266 JAMA 559, 559-60 (1991) [hereinafter *Gender Disparities*]; JACK, *supra* note 39, at 31.

80. See SHERWIN, *supra* note 58, at 152.

81. See *Gender Disparities*, *supra* note 79, at 560.

82. See Canetto, *Counseling the Suicidal Elderly*, *supra* note 40, at 93.

83. See *id.* at 94. However, the evidence provided is numerical, as opposed to proportional, which may be more appropriate here since elderly women outnumber elderly men.

84. See *id.*

85. See *id.* at 93.

cared for by their husbands.<sup>86</sup> There is also evidence that the institutionalized elderly, who are mostly women, are also at increased risk for suicide.<sup>87</sup> Furthermore, these financially based health care gender differences may also be due to the fact that women are more likely than men to suffer from chronic illnesses, due to longer life expectancy. Since such illnesses require longer and more extensive health care, they place additional strain on the already limited financial resources of women.<sup>88</sup> Therefore, because women experience more difficulty in access to and a lower quality of health care than men, it is reasonable to conclude they are more likely to consider and request physician-assisted suicide to prevent or relieve themselves and others of financial and emotional burden.<sup>89</sup> This likelihood to consider and request suicide is an under-protection of women.

Second, the lower quality of health care for women may also be due to a lack of attention to women's health in modern medicine and its androcentric biases.<sup>90</sup> This thereby contributes to more physically ill women. Ironically many illnesses, such as heart disease, that affect both men and women are generally thought of as "male diseases," despite the fact that heart disease is a leading cause of death in older women.<sup>91</sup> Consequently, there exists a lack of gender sensitive clinical research, in addition to the specific exclusion of women from studies.<sup>92</sup> For example, the 1985 study on the effects of cholesterol-lowering drugs, which found an "aspirin a day" may prevent heart attacks, was a study which specifically excluded women.<sup>93</sup> Furthermore, clinical research on illnesses that affect more women than men, or are

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86. *See id.* Only 18% of disabled women are cared for by their husbands. In contrast, 55% of disabled men are cared for by their wives. *See id.*

87. *See* OSGOOD, BRANT & LIPMAN, *supra* note 41, at 9. *See also* Osgood & Eisenhandler, *supra* note 4, at 365-68 (discussing acquiescent suicide).

88. *See* Canetto, *Counseling the Suicidal Elderly*, *supra* note 40, at 94.

89. *See* Canetto, *supra* note 18, at 228. In a survey conducted in Oregon, of the 20% of physicians who had been requested to assist their patients death, 83% of their patients cited reasons that included financial pressure. Mike McManus, *Right to Die?*, DALLAS MORNING NEWS, Oct. 21, 1997, at 15A.

90. *See* Carol Jonann Bess, *Gender Bias in Health Care: A Life or Death Issue for Women with Coronary Heart Disease*, HASTINGS WOMEN'S L.J. 41, 41-52 (1995); Sue V. Rosser, *Revisiting Clinical Research: Gender and the Ethics of Experimental Design*, in FEMINIST PERSPECTIVES IN MEDICAL ETHICS 127, 127-28 (Helen Bequaert Holmes & Laura M. Purdy, eds., 1992); SHERWIN, *supra* note 58, at 224; Wolf, *Shifting Paradigms*, *supra* note 1, at 405 & n.61.

91. Rosser, *supra* note 90, at 129.

92. *See id.* at 131.

93. *Id.* at 129. The primary reasons for the exclusion of women is to obtain "cleaner data" which may be interfered by estrus or menstrual cycles, to prevent possible fetal abnormalities and pregnancy complications of pregnant subjects, and because there are higher incidences of particular illnesses in men. *Id.* at 131.

female-specific, are minimal and receive little funding because such research has low priority and prestige in medicine.<sup>94</sup> For example, studies on the use of antidepressants were initially conducted exclusively on men. This practice occurred despite the fact that women have greater incidences of clinical depression and other mental illnesses, and are also prescribed more antidepressants than men.<sup>95</sup> Unfortunately, the lack of attention to gender differences and the specific exclusion of women in clinical research studies have produced medical treatments and medications of unknown or harmful effects to women, or are completely inappropriate for women.<sup>96</sup> Thus, women receive a lower quality of health care and more physically ill women become susceptible to consider and request physician-assisted suicide. This negative and disproportionate effect is also considered an under-protection of women.

However, the prevalence of gender-insensitive research and the scarcity of female-specific research is declining. The women's health movement of the 1970s led to an increased awareness of women's health issues by encouraging considerations of gender differences in both clinical research and pharmacology development.<sup>97</sup>

#### F. PHYSICIAN-PATIENT RELATIONSHIP

In view of the focus on the particular MDEL of physician-assisted suicide, gender differences in the requisite physician-patient relationship will have significant implications on its practice.

First, consideration of the traditional medical practice philosophy of paternalism is necessary. Paternalism dictates that it is the

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94. *See id.* at 130. Low priority, prestige and limited funding may be due to the disproportionate number and percentages of men on funding and peer review committees. *Id.* at 128-29.

95. *See Gender Disparities, supra* note 79, at 559.

96. *See Rosser, supra* note 90, at 129.

97. *See id.* at 134; *Shifting Paradigms, supra* note 1, at 405 & nn. 62-64. *See also* Pat Milmoie McCarrick, *Scope Note 27: Gender Issues in Health Care*, 5 KENNEDY INST. ETHICS J. 61 (1995) (providing a thorough review of literature on gender differences in the practice of medicine and research). Because of this recent increased focus on women's health, it is even more important that physicians receive continuous education on pain control treatment and medications as they relate to women. *See* Leon Jaroff, *Killing the Pain Doctors Find That an Opiate Works Better on Women*, TIME, Nov. 11, 1996, at 75 (reporting gender differences in reactions to pain and pain medications).

physician's role to direct medical care and make decisions about treatment.<sup>98</sup> The patient's role is to comply with the physician's orders<sup>99</sup> because "doctors know best." Although paternalism acknowledges and considers the patient's general preferences and attitudes towards care and treatment, the patient only has a minimal role in decision-making.<sup>100</sup> When physicians face what they believe is a patient's irrational choice, paternalism allows physicians to disregard or override the choice as "not being in the patient's true interests."<sup>101</sup> Under this philosophy, physicians have more power than patients in medical care and treatment decisions.

Paternalism is still a widely practiced philosophy by physicians, whose population majority is still made up of men, despite recent attempts to achieve more balanced positions of power.<sup>102</sup> This power imbalance is most predominate in male physician-female patient relationships,<sup>103</sup> which comprise the majority of physician-patient relationships. Moreover, this type of relationship is also predominate in right-to-die cases.<sup>104</sup> Thus, since more men than women in the United States are accepting of a woman's death by suicide,<sup>105</sup> it is likely male physicians may be more willing to grant a woman's request for physician-assisted suicide.<sup>106</sup> This effect is an under-protection of women.

The likelihood of a male physician granting a woman's request, is believed by some to be a reaffirmation of socialization and traditional gender roles that characterize women as helpless and weak.<sup>107</sup> Professor of Psychology Silvia Sara Canetto explores this belief and proposes that if "assisted suicide is perceived as compatible with femininity, then women may be at greater risk than men of viewing themselves (and being viewed by others) as acceptable candidates for

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98. See Dan W. Brock & Steven A. Wartman, *When Competent Patients Make Irrational Choices*, in CONTEMPORARY ISSUES IN BIOETHICS 109 (Tom L. Beauchamp & LeRoy Walters eds., 4th ed. 1994).

99. See *id.*

100. See *id.* at 110.

101. *Id.*

102. See SHERWIN, *supra* note 58, at 137-53. It is important to note that there have also been recent attempts to equalize the balance of gender in the physician population through increased applications and acceptances of women into medical school. However, this may be a moot point for purposes of this discussion. See *infra* note 113 and accompanying text.

103. See Miles & August, *supra* note 23, at 85.

104. See *id.* at 85-86.

105. See *supra* text accompanying notes 43-44.

106. See Canetto, *supra* note 18, at 228.

107. See *id.*

assisted suicide.”<sup>108</sup> Physician-patient miscommunication may also compound this problem. A woman’s request is more likely to be misinterpreted by her physician, who is likely to be male.<sup>109</sup> Psychiatrist Susan Block states a woman “may be saying ‘give me your relationship,’ and he [a physician] may be saying, ‘you want me to kill you, I’ll kill you.’”<sup>110</sup> This may also be due to the philosophy of paternalism. Therefore, it may be reasonable to expect paternalism to contribute to the negative and disproportionate effect of under-protecting women since physicians may view women’s requests for physician-assisted suicide as appropriate assistance to the “helpless and weak” gender.

However, this under-protection expectation may not be completely accurate in view of physician related data. A study has found that although over 75% of California physicians polled in 1988 believed patients should have a right to physician-assisted suicide, only 51% said they would practice it if legalized.<sup>111</sup> Additionally, a series of surveys conducted in 1990 and 1991 revealed that the majority of hospice physicians do not support physician-assisted suicide, nor would practice it if requested by a patient.<sup>112</sup> Nevertheless, one can expect more future physicians to be willing to practice physician-assisted suicide; this is in view of the American Medical Student Association’s recent submission of an amicus curiae brief to the United States Supreme Court supporting its practice.<sup>113</sup>

Negative and disproportionate effects of over-protecting women may also be caused by paternalism. While its practice may be decreasing, many physicians still paternalistically withhold medical information from women believing that they are unable to interpret the information correctly.<sup>114</sup> Women have traditionally been viewed as “lacking the qualities of autonomy and rationality considered preconditions for the exercise of valid consent.”<sup>115</sup> For example, MDEL on

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108. *Id.* at 229. Furthermore, Dr. Herbert Cohen, a Dutch physician practicing euthanasia, states that women’s requests for assistance in death can be “stronger, more existential” than men’s requests. HENDIN, *SEDUCED BY DEATH*, *supra* note 23, at 50.

109. *See* Colen, *supra* note 19, at 17.

110. *Id.*

111. *See* WEBB, *supra* note 15, at 383-84.

112. *See* Robert J. Miller, *Hospice Care as an Alternative to Euthanasia*, 20 L. MED. & HEALTH CARE 127, 129-31 (1992).

113. *See* Salomeh Kejhani & Julie I Boyer, *Student Challenges to the Medical Establishment*, 278 JAMA 1118 (1997).

114. *See* SHERWIN, *supra* note 58, at 224.

115. Nancy S. Jecker, *Physician-Assisted Death in the Netherlands and the United States: Ethical and Cultural Aspects of Health Policy Development*, 42 J. AM. GERIATRICS SOC’Y 672, 676 (1994).

behalf of women, more frequently than MDEL on behalf of men, are delegated to their husbands, parents and the courts.<sup>116</sup> When medical treatment decisions need to be made for incompetent female patients, who have expressed their preferences prior to incompetence, courts are more reluctant to acknowledge these preferences than for similarly situated male patients.<sup>117</sup> Prior preferences evidenced by women's values and choices are viewed as "immature, emotional, or unformed," whereas men's are viewed as "mature and rational, thus forming a more solid basis upon which to infer present preferences."<sup>118</sup> Additionally, a study of 22 right-to-die court cases, involving termination of life-sustaining medical treatment for similarly situated incompetent patients lacking advanced directives, found that courts are more likely to construct a man's preference to be termination of treatment (to escape medical assault and dehumanization) than to construct a woman's preference to be termination of treatment (to avoid medical neglect).<sup>119</sup> Thus, if life-sustaining medical treatment for men is considered an assault more than it is for women, discussion of physician-assisted suicide may occur more often with male patients than with female patients.<sup>120</sup> Professor Nancy S. Jecker claims this is rooted in the traditional gender role stereotypes of women as "properly weak and dependent on others for support" and men as "strong and autonomous," whereby the sick role is more compatible with femininity.<sup>121</sup> Therefore, "[i]f women's requests to forego life-sustaining treatment and be allowed to die are more likely to be discounted than men's requests, it is reasonable that women's requests for physician-assisted suicide would also be refused more frequently than men's would be."<sup>122</sup> Thus, the result is in an over-protection of women.<sup>123</sup>

Over-protection of women in the practice of physician-assisted suicide may also be caused by the stereotypical attitude of women as "excessively anxious, devious, and unintelligent."<sup>124</sup> This leads to the

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116. *See id.*

117. *See id.*

118. *Id.*

119. *See Miles & August, supra* note 23, at 86.

120. *See Jecker, supra* note 115, at 676. This reasoning has also been applied to the practice and discussion of withholding life-sustaining treatment of never-competent male patients and of involuntary active euthanasia for male patients. *See id.* at 677.

121. *Id.* at 676.

122. *Id.*

123. In other words, this would be an under-protection of men.

124. SHERWIN, *supra* note 58, at 224.

characterization that women's health complaints are rooted in emotional rather than actual physical causes.<sup>125</sup> This stereotypical characterization unfortunately contributes to physicians' failure to give appropriate medical acknowledgment to women's complaints. For example, many physicians consider women's complaints to be an exaggeration of ailments and pain, whereas men's are most often considered serious.<sup>126</sup> Socialization of gender roles are proposed to be the cause for this. Men frequent physicians and hospitals less than women,<sup>127</sup> and men may be more embarrassed or find it more difficult than women to seek help or alter their work schedules for physician visits.<sup>128</sup> Men may also be taken more seriously than women because they are socialized as the stalwart gender and thus, are likely to seek help only when there is significant pain or cause for concern—underusing medicine. Whereas women, socialized as the weaker gender, are less inhibited to seek medical help—overusing medicine.<sup>129</sup> Furthermore, women are more often than men judged incompetent which has been associated with the stereotypical female trait of irrationality.<sup>130</sup> Thus, women may be over-protected by inappropriate denials of their requests for physician-assisted suicide, since they are not taken seriously by their physicians and are often judged incompetent.

Gender differences in the quality of diagnosis and therapeutic measures may also have negative and disproportionate effects on women in the practice of physician-assisted suicide. For example, studies show that physicians perform more extensive tests and provide more timely treatment for men than for women, even when their complaints are similar.<sup>131</sup> Men also receive more major diagnostic and therapeutic interventions for their illnesses such as kidney transplants, testing for lung cancer and cardiac catheterization.<sup>132</sup> Socialization of

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125. See *Gender Disparities*, *supra* note 79, at 561.

126. See *id.*

127. In 1994, physicians had an average of 7.0 visits per year by their female patients and an average of 5.2 visits per year from their male patients. In 1995, 59.7% of all visits to office-based physicians were made by women. STATISTICAL ABSTRACTS OF THE UNITED STATES 124 (117th ed., 1997).

128. See *Gender Disparities*, *supra* note 79, at 561.

129. See Dority, *supra* note 28, at 16.

130. See Downie & Sherwin, *supra* note 7, at 308, 320-21.

131. See Chelmer L. Barrow, Jr. & Kirk A. Easley, *The Role of Gender and Race on the Time Delay for Emergency Department Patients Complaining of Chest Pain to be Evaluated by a Physician*, ST. LOUIS U. PUB. L. REV. 267 (1996) (reporting that women waited significantly longer than men to be examined by an emergency department physician); JACK *supra* note 38, at 112; SHERWIN, *supra* note 58, at 224.

132. See *Gender Disparities*, *supra* note 79, at 560.

gender roles may be the cause of these differences. Consider that it is generally assumed men have greater obligations and contributions to society and are their families' primary financial contributor.<sup>133</sup> Thus, the greater need for more aggressive and timely medical actions performed for men than for women. These studies also show that quality of health care is lower for women despite the fact that women frequent physicians and receive minor and routine tests more often than men.<sup>134</sup> Thus, women more likely suffer needlessly from serious physical illness. Additionally, evidence shows that physicians prescribe more medications to women for all and any kinds of illnesses, even after factors such as age and seriousness of illness are controlled.<sup>135</sup> Over-testing and over-medicating may then lead women to consider and request physician-assisted suicide, as an attempt to be free from medical intervention. This would be an additional under-protection of women in the practice of physician-assisted suicide.

### III. REGULATION OF PHYSICIAN-ASSISTED SUICIDE

The negative and disproportionate effects on women, both under-protection and over-protection, that are caused by gender differences, will be best overcome by completely revamping our culture: socialization and stereotypes, education, employment and health care. However, addressing any of these cultural problems requires a long-term commitment. In view of the Oregon Death with Dignity Act, time may be something vulnerable Americans, specifically women, do not have. Although efforts to address these cultural problems should continue, a solution to minimize the effects of gender differences in the practice of physician-assisted suicide is needed immediately.

One solution is a two-tiered policy proposal that would be specifically tailored to women and men who request physician-assisted suicide. However, the serious constitutional equal protection issues raised with such a facially gender-biased proposal are beyond the scope of this discussion. Moreover, many would argue that such a proposal is an unacceptable paternalistic approach. Feminists, especially liberal feminists, believe it would hinder the goal of "formal

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133. See *id.* at 561.

134. See SHERWIN, *supra* note 58, at 224.

135. See Canetto, *Counseling the Suicidal Elderly*, *supra* note 40, at 91.

gender equality.”<sup>136</sup> Their goal is to minimize the effect of gender differences, not to create more differences to overcome. Therefore, the most feasible solution to deal with the gender differences discussed, and the under-protection and over-protection effects on women, would be a gender-neutral policy for the practice of physician-assisted suicide.

Two policy approaches are generally recognized for the practice of physician-assisted suicide. The first is a toleration policy whereby assisted suicide is a criminal act, yet under certain circumstances where prescribed guidelines are followed, physician-assisted suicide can be a legal defense.<sup>137</sup> Evaluation of the assisted suicide act is performed by either an established group or the court. This narrow and conservative approach is similar to the practice in the Netherlands.<sup>138</sup> Supporters of this approach believe that this is the most effective way to prevent abuse and protect the most vulnerable groups of society, such as women.<sup>139</sup> This is because of the case-by-case nature of the practice and its remaining criminal status. The second policy approach is the legal recognition and regulation of physician-assisted suicide.<sup>140</sup> This approach grants patients an affirmative right to request and receive physician assistance in their suicide, so long as regulations are strictly followed. Exemplifying this approach is the Oregon Death with Dignity Act. To determine the most appropriate approach to the practice of physician-assisted suicide in the United States, examination of the Netherlands’ practice and Oregon’s statute is necessary. Examination will show how these two approaches in part succeed and in part fail to prevent gender differences from causing negative and disproportionate effects on women. I conclude that the recognition and regulation approach of physician-assisted suicide is the more appropriate approach for the United States.

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136. Karen H. Rothenberg, *Feminism, Law, and Bioethics*, 6 KENNEDY INST. ETHICS J. 69, 70 (1996) (discussing the four major feminist legal theories: liberal, cultural, radical and postmodern feminism).

137. See William J. Winslade, *Physician-Assisted Suicide: Evolving Public Policies*, in PHYSICIAN ASSISTED SUICIDE 233 (Robert F. Weir ed., 1997).

138. See *infra* text accompanying notes 141-43.

139. See Winslade, *supra* note 137, at 234.

140. See *id.* at 233.

## A. THE NETHERLANDS APPROACH OF TOLERATION

Since 1973, the Dutch have openly practiced physician-assisted suicide.<sup>141</sup> Many government and health care officials in the Netherlands believe that the best way to control the practice of physician-assisted suicide and prevent abuse is through "legalization and openness."<sup>142</sup> What is widely misunderstood about the Netherlands approach, is that the practice of any form of euthanasia and physician-assisted suicide is not affirmatively legalized by statute. Rather, the practice is only decriminalized and tolerated, if and only if, the physician follows the strict guidelines set by the Royal Dutch Medical Association (RDMA). In 1990, the RDMA set forth standardized guidelines which a physician must follow in order to successfully use physician-assisted suicide as a legal defense: 1) the request of the patient must be voluntary, 2) it must be well-informed and well-considered, 3) it must also be a durable wish, 4) there exists unacceptable physical suffering without alternatives for relief and 5) the physician must consult with a colleague.<sup>143</sup> This approach is unlikely to be adequate for the United States because of the significant differences in culture, health care access and quality, and in the physician-patient relationship. Nevertheless, Americans can learn from the Dutch by analyzing how their approach succeeds and fails to prevent negative and disproportionate effects on women.

1. *The Differences: Cultural, Health Care Access and Quality, and the Physician-Patient Relationship*

Culture significantly affects all important aspects of life, especially the way in which a society handles controversial issues. The Dutch are known to be liberal on many controversial issues such as drug use, prostitution and MDEL. Americans, however, are extremely conservative and take small, slow steps one at a time towards resolving controversial issues. This difference is likely

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141. For a thorough discussion on the history of aid-in-dying practices in the Netherlands, see PETER SINGER, *RETHINKING LIFE AND DEATH: THE COLLAPSE OF OUR TRADITIONAL ETHICS* 143-47 (1994).

142. Alison C. Hall, *To Die with Dignity: Comparing Physician Assisted Suicide in the United States, Japan, and the Netherlands*, 74 WASH. U. L.Q. 803, 825 (1996). Professor of Bioethics and Law, Alan Meisel agrees that without legalization, physician-assisted suicide cannot be regulated. See Alan Meisel, *Physician-Assisted Suicide: A Common Law Roadmap for State Courts*, 24 FORDHAM URB. L.J. 817, 820 (1997).

143. See Hall, *supra* note 142, n.167.

because the Dutch population is more homogenous<sup>144</sup> and thus, they are more likely to share the same foundations that define their mores. On the other hand, the American population is extremely heterogeneous, and known as the "melting pot" of the world. This greater heterogeneity is accompanied by greater disparities in wealth and power. These disparities create groups of people that are disempowered and underrepresented and thus, vulnerable to abuses in society. Another cultural difference between the Dutch and Americans is the attitude towards the elderly population. Europeans, including the Dutch, value the wisdom and dignity which comes with age and respect their elders.<sup>145</sup> However, Americans value vitality, beauty and youth and treat their elders in hospitals as inconvenient nuisances.<sup>146</sup> Therefore, because the Dutch are more homogenous and have a greater respect for their elderly, they are less likely to abuse the practice of physician-assisted suicide than Americans.

Access to and quality of health care are also significant factors that affect the practice of physician-assisted suicide. The Dutch provide universal access to health care through a combination of sickness funds, private insurance and government programs.<sup>147</sup> This universal access system provides quality health care with extensive medical care in hospitals, nursing homes and at home.<sup>148</sup> Many believe such a system prevents patients from feeling emotionally and financially coerced request and commit physician-assisted suicide. This is evidenced in that the reasons of fear and avoidance of being a burden to others are offered less frequently by the Dutch than by Americans. For example, 24-33% of the Dutch would consider physician-assisted suicide to avoid being dependent on others, compared to 47-60% of Americans.<sup>149</sup> Similarly, only 4% of the Dutch would consider physician-assisted suicide to avoid being a burden on their relatives, compared to 47% of Americans.<sup>150</sup> The most frequently offered reasons by the Dutch for justifying the practice of euthanasia and physician-assisted suicide are to relieve unbearable and endless suffering, and to

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144. See Wolf, *Gender, Feminism and Death*, *supra* note 6, at 296.

145. See HENDIN, *SEDUCED BY DEATH*, *supra* note 23, at 151-53.

146. *Id.* at 152.

147. See Jecker, *supra* note 115, at 672, 674.

148. See Margaret Battin, *Voluntary Euthanasia and the Risks of Abuse: Can We Learn Anything from the Netherlands?*, 20 L. MED. & HEALTH CARE 133, 142 (1992).

149. See Jecker, *supra* note 115, at 677 (citing two different studies performed in the Netherlands).

150. See *id.*

avoid a loss of dignity.<sup>151</sup> Since the Dutch provide universal access to and quality health care, requests for physician-assisted suicide are likely to be more autonomous than those by Americans who suffer from egregious problems in health care. Thus, in view of the fact that more American women than men suffer from these problems,<sup>152</sup> physician-assisted suicide abuse of women is more likely to occur in the United States than in the Netherlands.

The physician-patient relationship differences between the Netherlands and the United States is probably the most significant factor affecting the practice of physician-assisted suicide. The physician-patient relationship is much stronger and more consistent in the Netherlands than in the United States. Because there is universal access to health care in the Netherlands, Dutch physicians and their patients have a closer, more trusting and permanent relationship than do physicians and patients in the United States.<sup>153</sup> In general, the United States fails to facilitate this kind or this close of a relationship, because of health care access and quality problems. The physician-patient relationship is considered by the Dutch to be a "major source of patient protection"<sup>154</sup> for both women and men. Specifically, the Dutch physician-patient relationship provides greater patient protection than does the American one. The Dutch physicians are more likely to provide a greater quality of treatment for illness and pain, and are better able to determine the voluntariness of their patient's request for physician-assisted suicide. This is partially due to the physician having more knowledge about their patient's medical history, family and financial support, and the patient as a person. On the other hand, the Dutch physicians and medical profession are generally not challenged as much as they are in the United States.<sup>155</sup> Thus, Dutch physician-patient relationships may be more unequal in power than those in the United States, causing some of the previously discussed problems associated with paternalism. Nevertheless, the more closer and permanent physician-patient relationships in the Netherlands, in addition to cultural respect for their elderly, makes the Netherlands more likely than the United States to have fewer negative and disproportionate effects on women in the practice of physician-assisted suicide.

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151. *See id.*

152. *See supra* text accompanying notes 77-97.

153. *See* SINGER, *supra* note 141, at 158.

154. HENDIN, *SEDUCED BY DEATH*, *supra* note 23, at 180.

155. *See id.*

## 2. *Lessons to be Learned*

It is an ongoing debate whether physician-assisted suicide in the Netherlands is experiencing a slippery slope occurrence of having gone beyond its intended boundaries.<sup>156</sup> Evidence that a slide is not occurring is provided by the Rummelink Study on MDEL which was sponsored by the Dutch government in 1990. This study investigated approximately 10,000 deaths and found that only 400 deaths were caused by physician-assisted suicide, and only two thirds of the requests for physician-assisted suicide were granted.<sup>157</sup> This is offered as support that there is no "death on demand" since physicians do not easily and blindly grant their patients' requests.<sup>158</sup> Another study conducted between 1990 and 1995 found that although the number of requests for aid-in-dying increased, most requests were still not granted.<sup>159</sup> Yet, this study also found that 39% of physicians who once held an extreme position against the practice of physician-assisted suicide now hold a moderate position because of their experiences with terminal patients.<sup>160</sup> This change in position may predict a future change in the ratio of requests to grants of physician-assisted suicide. Furthermore, the lack of a gender difference in the incidences of euthanasia or physician-assisted suicide provides additional evidence of no slippery slope occurrence. A 1990 Dutch nationwide study of MDEL found that percentages did not differ significantly between genders.<sup>161</sup> Moreover, in incidences of euthanasia and related MDEL, the patients were more likely to be men than

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156. Professor Wibren van der Burg wrote a lengthy article describing the different forms of the slippery slope argument. He states, "[t]he basic structure of the argument is rather simple: if we allow A, B will necessarily or very likely follow (for A and B we can fill in certain acts or practices like euthanasia; B is morally not acceptable; therefore, we must not allow A either." Wibren van der Burg, *The Slippery Slope Argument*, 102 *ETHICS* 42, 42 (1991).

157. See Johannes J.M. van Delden, *The Rummelink Study: Two Years Later; Assisted Suicide*, 23 *HASTINGS CENTER REP.*, Nov.-Dec. 1993, at 24, 25 (1993).

158. However, a 1992 article reported 1 in 50 deaths in the Netherlands were from voluntary euthanasia, and the approximate total of these deaths per year was 2300. See SINGER, *supra* note 141, at 143. For more statistics and different interpretations of the Rummelink Study, see Lonnie R. Bristow, *Report of the Board of Trustees of the American Medical Association*, 10 *ISSUES L. & MED.* 81 (1994) and Herbert Hendin, *Physician-Assisted Suicide and Euthanasia in the Netherlands*, 277 *JAMA* 1720 (1997).

159. See Paul J. van der Maas et al., *Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995*, 335 *NEW ENG. J. MED.* 1699, 1705 (1996) [hereinafter *End of Life in the Netherlands*].

160. See SINGER, *supra* note 141, at 143.

161. See Paul J. van der Maas, Johannes J.M. van Delden, Loes Pijnenborg & Casper W.M. Looman, *Euthanasia and Other Medical Decisions Concerning the End of Life*, 338 *LANCET* 669 (1991).

women.<sup>162</sup> Also, in a later 1995 study of MDEL, the majority (61%) of the reported physician-assisted suicides involved men.<sup>163</sup>

While there is no evidence of a slippery slope occurrence based on simple incidences of aid-in-dying, there is other evidence of this occurrence in the Netherlands. First, there is a lack of reporting aid-in-dying by physicians. The 1995 Dutch study found that only 41% of all cases were reported.<sup>164</sup> However, this marks a significant increase from the 1990 study which found that only 18% of the cases were reported.<sup>165</sup> This increase has been attributed to the enactment of a simplified notification procedure ensuring that physicians will not be prosecuted if guidelines are followed.<sup>166</sup> The majority of Dutch physicians (over 80%), believe that the reporting and review should be made to other physicians rather than to a coroner.<sup>167</sup> Second, access to and quality of health care in the Netherlands has decreased. There is evidence showing an erosion in the delivery and quality of hospice and palliative care for their terminally ill patients.<sup>168</sup> Third, the nature of the physician-patient relationship has changed.<sup>169</sup> Psychiatrist Herbert Hendin believes that the practice of euthanasia and physician-assisted suicide in the Netherlands has empowered physicians far more than patients, and has increased the paternalistic power of medicine.<sup>170</sup> For example, more than 50% of physicians now feel free to suggest a form of euthanasia to their patients. Hendin has found that the practice, initially "intended as an unfortunate necessity in exceptional cases[,] has become a routine way of dealing with serious or terminal illness, so much that doctors are often the first to suggest

162. *See id.*

163. *See End of Life in the Netherlands*, *supra* note 159, at 1703. However, the majority (57%) of euthanasia practices reported in the study involved women. *See id.* This may show a preference among women to chose euthanasia over physician-assisted suicide, or possibly a preference among men to chose physician-assisted suicide over euthanasia.

164. *See Hendin*, *supra* note 158, at 1721.

165. *See id.*

166. *See id.* The government is continuing its efforts to revise its notification procedure in order to further increase the number of cases reported. *See Gerrit van der Wal et al., Evaluation of the Notification Procedure for Physician-Assisted Death in the Netherlands*, 335 *NEW ENG. J. MED.* 1706-11 (1996).

167. *See van der Wal et al.*, *supra* note 166, at 1706.

168. *See Hendin*, *supra* note 158, at 1722 (proposing that the availability of all forms of euthanasia may be responsible for the decade lag in palliative care development in the Netherlands). Yet, it should be noted that this is contradicted by other critics.

169. *See id.*

170. *See HENDIN, SEDUCED BY DEATH*, *supra* note 23, at 182, 183; Herbert Hendin, *Seduced by Death: Doctors, Patients and the Dutch Cure*, 10 *ISSUES L. & MED.* 123, 163 (1994) [hereinafter Hendin, *Doctors, Patients and the Dutch Cure*].

euthanasia to terminally ill patients.”<sup>171</sup> If these three aspects possibly represent the future practice of physician-assisted suicide in the United States, then women will continue to disproportionately experience negative effects. Specifically, a lack of reporting will inhibit the tracking of possible abusive gender patterns. Also, the decrease in hospice and palliative care which will worsen the present health care problems for women, and the increase of will both cause under-protection and over-protection effects on women’s requests for physician-assisted suicide.

Slippery slope evidence showing the greatest negative and disproportionate effect on women is the failure of Dutch physicians to appropriately and adequately consider a patient’s mental health when they request aid-in-dying. Dutch physicians are not required to seek psychiatric consultations for aid-in-dying. Consultation for such patients’ requests that are based, or so believed to be based by the physicians, on physical illness are rare.<sup>172</sup> This may be due to the fact that most psychiatrists believe the primary physicians should decide if and when a consultation is needed.<sup>173</sup> Thus, the lack of psychiatric consultations will likely increase the granting of questionably competent and voluntary requests by women for physician-assisted suicide. This may have especially negative effects for American women, whose requests are already likely deemed questionably competent and voluntary.<sup>174</sup>

Extension of the RDMA guidelines provides further slippery slope evidence of negative and disproportionate effects on women. The RDMA guidelines were originally intended only to allow physician-assisted suicides for patients suffering from intolerable and incurable physical pain. However, these guidelines have recently been extended to cover cases where the patient does not suffer from physical pain. This extension was made in 1994 when the Dutch High Court decided not to prosecute a psychiatrist who assisted his patient, Hilly Bosscher, commit suicide.<sup>175</sup> Bosscher was a fifty-year old

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171. HENDIN, *SEDUCED BY DEATH*, *supra* note 23, at 182.

172. See Johanna H. Groenewoud et al., *Physician-Assisted Death in Psychiatric Practice in the Netherlands*, 336 *NEW ENG. J. MED.* 1795, 1801 (1997) (reporting that only three percent of an estimated 9700 requests for euthanasia and physician-assisted suicide received a psychiatric consultation).

173. See *id.* at 1801.

174. See *supra* text accompanying notes 58-59, 103-10, 114-35.

175. See Underwood, *supra* note 9, at 668-70 (citing to Kaufmann, *supra* note 27, at 816-19). Note that Bosscher’s first name has been referenced as both Hilly and Holly. However, I choose

woman who suffered from emotional pain but no physical pain.<sup>176</sup> She was severely depressed due to her divorce from an abusive husband, the death of her father and the deaths of her two sons (one by cancer and the other by suicide).<sup>177</sup> Considering that Bosscher had already attempted suicide once before and believing she would attempt it again, her psychiatrist Dr. Chabot agreed to assist her in order to prevent a violent suicide or another failed attempt which would exacerbate her emotional pain.<sup>178</sup> Before assisting her, Chabot presented Bosscher's case to seven colleagues and five of them concurred with his conclusions.<sup>179</sup> However, the concurrences were based solely on Chabot's presentation of Bosscher's case and did not include in-person examinations of Bosscher.<sup>180</sup> Upon hearing the case, the court found Bosscher's emotional pain comparable to meeting the physical pain requirement; the court held that in exceptional circumstances, physician-assisted suicide may be practiced among patients suffering only from intolerable emotional pain.<sup>181</sup>

Hendin believes the extension to emotional pain allows "too little incentive to conduct therapy aimed at the underlying cause of depression or a suicide wish."<sup>182</sup> Furthermore, the extension victimizes depressed patients who fail to respond quickly to psychiatric treatments.<sup>183</sup> Since most depressed patients are women,<sup>184</sup> it is thus reasonable to expect that women would disproportionately and inappropriately be granted their physician-assisted suicide requests. However, this expectation may not be completely accurate. A Dutch study in 1996 found that although requests for physician-assisted suicide are not uncommon in psychiatric practice, these requests are rarely granted.<sup>185</sup> Moreover, in those cases where a physician-assisted

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to use Hilly after an ALLNEWS Westlaw search found news pieces referencing Bosscher as only Hilly.

176. *See id.* at 668.

177. *See Hall, supra* note 142, at 828 n.174; Underwood, *supra* note 9, at 668.

178. *See Kaufmann, supra* note 27, at 817.

179. *See id.*

180. *See Underwood, supra* note 9, at 668.

181. *See Hall, supra* note 142, at 827-28; Underwood, *supra* note 9, at 670.

182. Hendin, *Doctors, Patients and the Dutch Cure, supra* note 170, at 163.

183. *See id.*

184. *See supra* text accompanying notes 45-59.

185. *See Groenewoud et al., supra* note 172, at 1795 (reporting that only two to five requests out of 320 requests were actually granted).

suicide was practiced by a psychiatrist, the patient was not only suffering emotionally, but also suffering physically from a serious illness that was often terminal.<sup>186</sup>

In 1995, the RDMA took action in response to the evidence of a possible slippery slope occurrence. This action was a three-part revision to its guidelines that favored physician-assisted suicide over euthanasia. It was an attempt to alleviate emotional stress of euthanizing physicians and to establish clearer responsibilities of both the physician and patient.<sup>187</sup> Professor James L. Underwood bluntly states “[t]hese revisions should reduce the chance of physicians acting with god-like autonomy.”<sup>188</sup> First, whenever possible, the patient should self-administer the fatal drug.<sup>189</sup> Second, the consulting physician must examine the patient and must be free from family or professional ties to the patient or the primary physician.<sup>190</sup> Third, if a requested physician is opposed to euthanasia, that physician must put the requesting patient in contact with a physician who is not opposed.<sup>191</sup> These revisions are helpful to determine how to avoid a slippery slope occurrence, and how to best regulate physician-assisted suicide in the United States.

#### B. THE UNITED STATES APPROACH OF RECOGNITION AND REGULATION

The first statute in the world that affirmatively legalized physician-assisted suicide for adult terminally ill patients began as a state voter initiative in the United States. This was Oregon's Measure 16, the Death with Dignity Act. It was passed by Oregon voters in November 1994 by a narrow margin of 52% to 48%.<sup>192</sup> However, the statute was not immediately enacted. A United States District Court enjoined enforcement of Measure 16, acknowledging significant controversial constitutional issues, and later found it a violation of the

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186. *See id.*

187. *See Hall, supra* note 142, at 827.

188. Underwood, *supra* note 9, at 677.

189. *See Hall, supra* note 142, at 827 n.172 (citing Marlise Simons, *Dutch Doctors to Tighten Rules on Mercy Killings*, N.Y. TIMES, Sept. 11, 1995, at A3).

190. *See id.*

191. *See id.*

192. Other similar initiatives have failed, including California's Proposition 161 in 1992, and Washington's Initiative in 1991 which failed by a narrow margin of 54-46%. *See Joyce Price, Term Limits Show National Appeal*, WASH. TIMES, Nov. 5, 1992, at A7; Jeff Stryker, *Voting on Death*, RECORDER, Oct. 1, 1992, at 8.

Equal Protection Clause of the Fourteenth Amendment.<sup>193</sup> However, the United States Ninth Circuit Court of Appeals vacated the lower court's decision based on the technicality that the right-to-life group suing lacked standing to sue since they failed to establish actual injury.<sup>194</sup> The right-to-life group appealed to the United States Supreme Court who later dismissed the appeal without comment in October 1997.<sup>195</sup> Through a special mail vote in November 1997, drawing the highest voter turnout in Oregon since 1963, voters rejected an attempt to repeal Measure 16 by a significantly greater margin than the first vote – 60% of voters in favor of physician-assisted suicide and 40% opposing it.<sup>196</sup>

### 1. *Provisions of the Statute*

Section one of the now codified Death with Dignity Act (Act) defines the words and phrases used throughout the Act. A terminal disease is defined as “an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six (6) months.”<sup>197</sup> Section two presents the four necessary conditions of the request which must be met in order to receive the lethal medication. The patient must 1) be an adult, 2) be suffering from a terminal disease, 3) request the lethal medication voluntarily and 4) request it in writing.<sup>198</sup> The written and signed request must be witnessed by two persons who can attest that the patient is “capable, acting voluntarily, and is not being coerced to sign the request.”<sup>199</sup> One of these witnesses must not be a relative to the patient, in a position to gain from the patient's death, nor associated with the health care facility where the patient is being treated or resides.

Section three of the Act provides numerous safeguards. These safeguards begin with the responsibilities of the attending physician who is required, *inter alia*, to 1) determine whether the patient has a terminal disease, is capable and has requested medication voluntarily,

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193. See *Lee v. Oregon*, 869 F. Supp. 1491, 1497 (D. Or. 1994).

194. See *Lee v. Oregon*, 107 F.3d 1382 (9th Cir. 1997).

195. See *Lee v. Harclerod*, 118 S. Ct. 328 (1997).

196. See Kim Murphy, *Voters in Oregon Soundly Endorse Assisted Suicide*, L.A. TIMES, Nov. 5, 1997, at A1.

197. Death with Dignity Act, OR. REV. STAT. tit. 13, ch. 127.800, § 1.01(12) (1997).

198. See *id.* ch. 127.810, § 2.01(1). However, note that disease of any kind is not permitted. This is a significant difference from the RDMA guidelines. See *supra* text accompanying note 143.

199. Death with Dignity Act, ch. 127.810, § 2.02(2).

2) inform the patient of the complete diagnosis, prognosis, risks and probable results of taking the medication, and all alternatives to physician-assisted suicide such as palliative care, 3) refer the patient to a consulting physician to confirm the patient's diagnosis, capability and voluntariness of the request for medication, 4) refer the patient for counseling if appropriate and 5) request the patient notify the next of kin.<sup>200</sup> The Act also requires the referral of a patient who may have a psychiatric or psychological disorder, determined by the primary physician, to undergo counseling or evaluation; furthermore, no medication is to be prescribed until it is determined that the patient does not have any disorder that impairs judgment.<sup>201</sup> Additionally, the patient is required to make an oral request for assistance and a written request to the attending physician, reiterating the oral request "no less than fifteen (15) days after making the initial oral request."<sup>202</sup> There are mandatory waiting periods of no less than fifteen days between the patient's initial oral request and the writing of the prescription for medication, and no less than 48 hours between the patient's written request and the writing of the prescription.<sup>203</sup> Lastly, documentation that all the requirements have been met must be provided and reported to the Health Division, who will review a sample of the patients' records and will provide statistical reports of the information gathered.<sup>204</sup>

Section four of the Act presents the physician immunities and liabilities. The Act provides immunity for physicians who in "good faith" comply with the Act's requirements.<sup>205</sup> This section also requires a physician, who is unwilling or unable to grant a request for physician-assisted suicide, to transfer upon request a copy of the patient's medical records to a new health care provider.<sup>206</sup> The liabilities and penalties for interfering with or failing to follow the requirements of the Act include a Class A felony prosecution with possible civil and criminal penalties.<sup>207</sup>

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200. *See id.*, ch. 127.815, § 3.01(1-6).

201. *See id.* § 3.03.

202. *Id.* § 3.06.

203. *See id.* § 3.08.

204. *See id.* §§ 3.09, 3.11.

205. *Id.* ch. 127.885, § 4.01(1-3).

206. *See id.* § 4.01(4).

207. *See id.* ch. 127.890, § 4.02(1-4); ch. 127.995.

## 2. Considerations

The Act's requirements are more stringent than the RDMA guidelines for the practice of physician-assisted suicide. This kind of strict and detailed regulation, providing more safeguards and placing more responsibility on the physician, is more likely than the RDMA guidelines to prevent abuses in the United States.

However, there are still flaws in the Act which will likely allow gender differences to continue causing the negative and disproportionate effects on women discussed in part two of this Article.<sup>208</sup> The first flaw is that the Act is not clear whether the six month prognosis for the patient requesting physician-assisted suicide is a prognosis with or without medical treatment. Without this clarification, it is possible that a woman's decision to forego treatment may be considered by her physician to be irrational, thereby unfairly judging her incompetent. Thus, the physician would refuse an appropriate request for physician-assisted suicide. Second, the Act fails to require psychiatric consultation for all patients which may lead to physicians granting questionable voluntary or genuine requests for physician-assisted suicide,<sup>209</sup> more likely to be from women than men.<sup>210</sup> Third, patients are not required to discuss palliative and hospice care options with specialists. Therefore, primary physicians may grant patients' requests that are made solely because of ineffective pain relief; such requests will more likely be from women than men, in view of their lack of access to and quality of health care.<sup>211</sup> Fourth, the lack of a physician's presence requirement during the actual lethal ingestion, risks a decision to act that is neither voluntary nor competently<sup>212</sup> made, also more likely which may also likely to be from women than men. Fifth, the immunity provided to physicians who comply with the statute allows a physician to "negligently misdiagnose a person's condition and competency and negligently prescribe a drug overdose, so long as

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208. An evaluation of proposed bills modeled after Measure 16 found that all the bills had the same flaws with regard to "safeguards concerning informed consent, mental competence, voluntariness, and restrictions of eligibility to the terminally ill." HENDIN, *SEDUCED BY DEATH*, *supra* note 23, at 173 (citing Daniel Callahan & Margot White, *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U. RICH. L. REV. 1-83 (1996)). The study concludes that the reason for these flaws is that the bills are written to protect the physicians, not to protect the patients. *See id.*

209. *See Lee v. Oregon*, 891 F. Supp. 1429, 1435 (1995).

210. *See supra* text accompanying notes 45-62.

211. *See supra* text accompanying notes 77-97.

212. *See Lee v. Oregon*, 891 F. Supp. at 1437.

those actions are in 'good faith.'"<sup>213</sup> This immunity adds to the problems arising from the imbalance of power in the physician-patient relationship that cause negative and disproportionate effects on women.<sup>214</sup>

For the many reasons discussed in this Article, the United States cannot simply follow the Netherlands practice of physician-assisted suicide. The United States has many more cultural problems and the differences between the two societies will significantly affect the practice of physician-assisted suicide.<sup>215</sup> Therefore, after examination of the Netherlands practice and the Oregon statute, the second policy approach of legal recognition and regulation is the most appropriate.<sup>216</sup> This detailed and more stringent approach will better minimize or prevent gender differences from contributing to negative and disproportionate effects on women, under-protection and over-protection, in the practice of physician-assisted suicide.

#### IV. MODEL GUIDELINES FOR REGULATION IN THE UNITED STATES<sup>217</sup>

In view of parts two and three of this Article, I propose guidelines and suggestions for regulating the practice of physician-assisted suicide in the United States. These proposals are divided into three sections: 1) prior review, 2) postmortem review and reporting and 3) prohibitions and liabilities.

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213. *Id.*

214. *See supra* text accompanying notes 98-106. Melinda A. Lee of the Oregon Health Sciences University, recently wrote an article that presents many of the implementation issues associated with the Oregon Death with Dignity Act. Such implementation issues include the question of what kind of physician is allowed to practice physician-assisted suicide (intern, primary care physician, experienced palliative care physician), deciding if pharmacists can inquire and refuse to fill a prescription intended for suicide and their potential liability, deciding how the cause of death is recorded on the death certificate, and confidentiality issues regarding families and other health care providers. *See Lee, supra* note 61, at 398-401.

215. *See supra* text accompanying notes 144-55.

216. *See Meisel, supra* note 142, at 820.

217. While this note focuses on the substance of the legislation, the process by which legislation is passed should also be considered. I agree that legislation providing the maximum protection for all citizens of different classes, races and gender would more likely come from a "representative democracy," as opposed to a grass roots "direct democracy" attempt like the Oregon statute. Daar, *supra* note 11, at 858-59. This is because direct democracy "will likely never produce the concentrated, often forced, compromise-oriented debate that can be achieved in the legislative process." *Id.* at 858. In a representative democracy, there is also more opportunity in the legislative process to consider a number of different proposed plans in order to pick apart and piece together the most optimal plan for the majority and minority. For a more extended discussion, see Daar, *supra* 11, at 799-859.

## A. PRIOR REVIEW

After completing a comprehensive review of physician-assisted suicide in the United States, Japan and the Netherlands, Alison C. Hall proposes seven legislative guidelines for prior review that provide an appropriate and adequate foundation for this section.<sup>218</sup>

Hall first requires that “[t]he patient must be a terminally ill adult. At least two independent corroborative medical opinions must agree that all other treatment options have been exhausted and the patient has less than one year left to live.”<sup>219</sup> To begin, I agree with Hall that the illness should be terminal, as opposed to an incurable and debilitating illness. Recognizing that this limitation is biased against those patients not suffering from a terminal illness and against those only suffering emotionally, I find the bias acceptable in order to prevent greater negative and disproportionate effects on women. Further, the current definition of a terminal illness includes patients suffering from an illness with a prognosis of six months to live.<sup>220</sup> However, I favor Hall’s one year prognosis as the definition since it provides more flexibility; this is in view of the fact that most prognoses are often inaccurate, and that life can almost indefinitely be prolonged with current medical technology.<sup>221</sup> Clarifying that the patient has less than one year to live, be it with or without medications and treatments, is necessary to prevent women from being coerced into submitting to or continuing with medical interventions. Also, stating that the prognosis may be with or without medications and treatments, acknowledges that a decision to forego them is not per se irrational. Therefore, the risk that women deciding to forego them, will be found irrational or incompetent to make MDEL is minimized or prevented. Following the 1995 RDMA revised guidelines, I would also require that the two corroborating medical opinions be from physicians who

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218. Hall, *supra* note 142, at 836-39. For some general guidelines on how physicians can provide a “good death” for their patients, but not necessarily assistance in suicide, see WEBB, *supra* note 15, at 397-99.

219. Hall, *supra* note 142, at 837 (footnotes omitted).

220. This definition is based on Congressional regulations for Medicare coverage of hospice care. See WEBB, *supra* note 15, at 400.

221. For a thorough discussion on the limitations and inaccuracies of prognoses, see Chevlen, *supra* note 46, at 337. Some have argued that prognoses are so arbitrary and inaccurate that the terminal illness standard should be changed to “an incurable condition causing intolerable, irremediable suffering.” Ernle W.D. Young et al., *Report of the Northern California Conference for Guidelines on Aid-in Dying: Definitions, Differences, Convergences, Conclusions*, 166 W. J. MED. 381, 383 (1997).

lack professional and family ties to the patient, and are not in the position of financial gain from the patient's action or inaction.

Secondly, Hall requires that "[t]he patient must undergo two rigorous psychiatric consultations to ensure legal competence. A patient's decision to end life should not be caused by depression or other concerns, such as being a burden to family or society."<sup>222</sup> This absolute guideline is significant for the prevention of negative and disproportionate effects on women in the practice of physician-assisted suicide.<sup>223</sup> However, I believe that a requirement for two psychiatric consultations is too burdensome for patients and physicians, and may lead to a lack of reporting. Thus, one consultation is more appropriate and sufficient, so long as it is an actual in-person examination of the patient. Furthermore, I propose a requirement that the consulting psychiatrist hold some kind of certification in diagnosing and treating depression and mental illness in the terminally ill patient population. Recognizing that many women are likely to be suffering financially and would not be able to afford such psychiatric consultations, it is necessary to develop a way for all women (rich or poor) to receive them. For example, if a physician or hospital allows or practices physician-assisted suicide, they should be required to provide free psychiatric consultations for all their patients who request physician-assisted suicide.<sup>224</sup> I would also propose that a group of physicians, psychiatrists, psychologists and sociologists, with experience in depression and suicidology, work together to determine what constitutes a "rigorous psychiatric consultation" of a terminally ill patient. Additionally, a recommended list of questions and issues, such as those regarding competency and voluntariness, for such consultations should be established. This list could be compiled into a standardized form or checklist in order to promote more accurate and less gender-biased determinations. This list or form would then be distributed to those

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222. Hall, *supra* note 142, at 837 (footnotes omitted). Although a woman should be free to base her decision to end her life on these or any other concerns, it is generally believed that to do so would make the decision a less than autonomous one.

223. This proposed guideline is similar to the suggested requirement offered by the court in *Lee v. Oregon*. The court suggested that the Oregon Death with Dignity Act should require that the patient "consult a certified social worker or other specialist to explore social services which might assist the person to live in greater comfort." *Lee v. Oregon*, 891 F. Supp. 1429, 1435 (1995) (although this decision was later vacated, it was only vacated due to a standing technicality). The court further stated that they were "unable to conceive of a set of facts under which it would be rational to not require mental and social evaluations by appropriately trained professionals." *Id.* at 1436.

224. This, along with the certification requirement, will require some administrative creativity that may be better left to hospital policymakers.

certified psychiatrists to diagnose and treat depression and mental illness in terminally ill patients. Lastly, if the consulting psychiatrist makes a finding of incompetence, there should be required efforts to establish competence through psychiatric counseling.<sup>225</sup> Medical care should not be focused solely on physical symptoms, but also on the psychological symptoms of terminally ill patients. Upon the reestablishment of competency, discussion of physician-assisted suicide could then resume.

Hall's third guideline requires the patients to "be in extreme pain that cannot be alleviated. The physician must concentrate on the pain and suffering of the patient, considering hospice care and other treatments. If all means have been exhausted and the patient is facing her remaining time suffering, the request for physician assisted suicide is valid."<sup>226</sup> Since pain is a major contributor to requests for physician-assisted suicide, and there is a tendency to under-treat patients with terminal illness,<sup>227</sup> this guideline should be expanded. First, access to quality primary and palliative care should be made a prerequisite. Palliative and hospice care should be explicitly offered and thoroughly discussed with the patient by a palliative care specialist; documentation of this should also be required. Second, determination that the pain cannot be alleviated should be made by a physician who has some kind of certification in palliative care for the terminally ill; this is similar to the proposed consulting psychiatrist certification in depression diagnosis and treatment. In view of the rapid developments in pharmaceutical and medical care technology, and its recent awareness of gender differences,<sup>228</sup> I would also propose increased education, as well as testing of palliative care through licensing exams.<sup>229</sup> Continued palliative care education should be required to renew the certification of the specialists.<sup>230</sup> This will ensure that palliative care

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225. See Downie & Sherwin, *supra* note 7, at 328.

226. Hall, *supra* note 142, at 837-38 (footnote omitted).

227. See Ann Alpers & Bernard Lo, *Does it Make Clinical Sense to Equate Terminally Ill Patients Who Require Life-Sustaining Interventions with Those Who Do Not?*, 277 JAMA 1705, 1707 (1997).

228. Dr. Foley, a recognized expert in palliative care and pain control, offers six rules physicians should follow when providing pain control and medications to their patients. See WEBB, *supra* note 15, at 100-03.

229. See *id.* at 48, 401 (explaining the deficiency in palliative-care education and information, and proposing new board certification and licensing exams in palliative care).

230. See *id.* I do not offer a plan for how this certification is to be issued nor for its renewal requirements. The American Medical Association may be better qualified to devise the certification and renewal plans. However, I offer the analogy of the Mandatory Continuing Legal Education program for practicing attorneys in support of this proposed idea.

improvements continue. Further, either the patient's primary physician or one of the two consulting physicians can be this certified palliative care specialist. Another option to ensure palliative care has been exhausted is to establish review committees that physicians could consult when making their determination.<sup>231</sup>

Fourthly, Hall requires that "[t]he decision to end life must be informed. A patient should be aware of the progression of the illness, the procedure for the assistance, and any other medically relevant information. Full disclosure is essential for the unobstructed exercise of the right of self-determination."<sup>232</sup> This guideline is similar to the requirement of informed consent for any type of medical interventions. Informed consent is one of the best coping tools a patient can have, since knowledge provides a sense of control and minimizes fear of the unknown.<sup>233</sup> I would further require that proof of the patient's informed decision be documented either by writing, video, audio or testimony of two independent witnesses.

The fifth required guideline that Hall proposes is that the decision to request physician-assisted suicide must be the patient's own choice and must be voluntary. In order to determine this, the factors of "pain, debilitation, and the quality of remaining life should be weighed by each individual patient. The choice should be discussed with, but not [coercively] influenced by the opinions of, family and friends. . . . The request should be made by signing a request form in the presence of two independent witnesses."<sup>234</sup> This guideline is likely to prevent significant negative and disproportionate effects on women. Emotional and financial coercion may be consciously unknown to the patient requesting physician-assisted suicide. Thus, this guideline, in conjunction with the psychiatric consultation requirement, must be adequately evidenced and appropriately documented.

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231. See Franklin G. Miller et al., *Regulating Physician-Assisted Death*, 331 *NEW ENG. J. MED.* 119-23 (1994). It has also been suggested there be a revision on drug legislation to decrease restrictions for prescribing drugs, such as marijuana, heroin and LSD, that provide effective pain control. For example, consider the passed California initiative legalizing the use of marijuana for medicinal purposes. See WEBB, *supra* note 15, at 404. Additionally, physician fear of disciplinary actions and criminal sanctions for effective pain control from controlled substances may be minimized through legislation, such as the proposed Pain Relief Act by the American Society of Law, Medicine and Ethics. See Johnson, *supra* note 71, at 13. The goal of this "Act is to terminate actions against providers engaging in justifiable pain management practices as early as possible in the disciplinary or criminal process." *Id.* at 10.

232. Hall, *supra* note 142, at 838 (footnote omitted).

233. See WEBB, *supra* note 15, at 207.

234. Hall, *supra* note 142, at 838 (footnotes omitted). I insert the word coercively because there are no decisions that are made without some influence from outside sources.

Further, I would propose a strict requirement that the physician-assisted suicide be practiced only if the initial request was by the patient; it should never be a suggestion by a physician.<sup>235</sup> In this growing period of managed care and cost management, there is likely to exist pressure on both the patient and the physician to consider or prefer physician-assisted suicide over continued costly medical treatment. Thus, "watchdog committees or regulatory procedures to ensure patient and family decision-making" should be formed.<sup>236</sup>

Hall's sixth guideline requires that the request for physician-assisted suicide be repeated and that the patient not be immediately assisted after only one request. "The physician may grant assistance only after the patient has requested [it] at least three times, with significant intervals between each request. . . . [and] during the intervals . . . the patient should consult with a group of people representing society's collective wisdom regarding the decision."<sup>237</sup> First, the phrase "significant intervals" needs to be more thoroughly defined. The only insight Hall provides is that the repeated requests cannot be made on consecutive days and "there must be a consequential time period between requests."<sup>238</sup> I agree with Hall that the repeated requests should not be made on consecutive days. Furthermore, I would require that at least one of the requests be made after both the psychiatric consultation and palliative care determination are performed, and after a determination is made that the request is informed and voluntary.<sup>239</sup> Additionally, there should be a requirement that no revocation of a request for physician-assisted suicide be made during the intervals of the three requests, in order to prevent the deaths of hesitant patients. Hall's proposal for a required patient consultation with a group of people knowledgeable about the patient's

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235. Despite the evidentiary and remedial difficulties of this, I believe it is still necessary for the protection of patients, and at the very least to reaffirm the message that physician-assisted suicide is completely and solely a patient's decision. But consider the argument that if physician-assisted suicide is legalized, in order to meet the requirement of informed consent for treatment, the patient must be informed of this option. See Chevlen, *supra* note 46, at 347. However, I believe this argument is flawed because it relies on the incorrect characterization of physician-assisted suicide as medical treatment.

236. WEBB, *supra* note 15, at 404.

237. Hall, *supra* note 142, at 838-39 (footnotes omitted).

238. *Id.* at 838 n.232.

239. Since this additional requirement would likely take a few days, it may ensure that the requests are repeated with sincerity and assurance.

situation and MDEL is an interesting one.<sup>240</sup> Hall envisions this group be made of educators, lay persons, civic leaders, clergy, philosophers and/or lawyers, who would be chosen by the patient to help evaluate their decision for physician-assisted suicide.<sup>241</sup> These people can provide the psycho-social support that has been found to be one of the best preventative measures of suicide.<sup>242</sup>

Hall's last required guideline is that the prescription for the lethal dosage of medication be administered by the patient's own hand. "Before handing over the prescription, the physician should ask the patient once again if she fully understands the outcome of her act. If there is any hesitation, then the physician should not prescribe the medication. This allows the patient complete autonomy."<sup>243</sup> This guideline is similar to the 1995 RDMA revised guidelines which state that whenever possible, the fatal drug should be administered by the patient. I would further require that the physician be present at the time the final act is performed as a safeguard to ensure that a voluntary, autonomous and competent decision is made. Additionally, if the patient expresses doubts or regrets about the recent ingestion of the lethal medication, the physician should be required to administer and seek emergency medical treatment to prevent the patient's death. Thus, this required presence would force more of the burden upon the physician to ensure that the guidelines are met. After all, the act is called "physician-assisted" suicide, which should require the presence of the physician at the time of death.<sup>244</sup>

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240. The administrative and funding details for this consultation may be best addressed by physicians and hospitals individually. On another note, those considering physician-assisted suicide may be opposed to this requirement, finding it an invasion of autonomy and privacy. This however, may require a balancing of individual and societal interests that would be better left to the courts or the democratic process to decide.

241. See Hall, *supra* note 142, at 839 n.233. See also WEBB, *supra* note 15, at 402 (describing such a group as "midwives to the dying" with expertise and training to deal with death).

242. See Novoselick, *supra* note 68, at D5 (concluding that as multiple sclerosis progresses, patients needed psycho-social support to help deal with their illness and for the prevention of suicide).

243. Hall, *supra* note 142, at 839.

244. Though the substantive guidelines for a regulation of physician-assisted suicide have been presented, the question of how these procedures are to be met still remains. The Bay Area Network of Ethics Committees (BANEC) has recently proposed advisory guidelines for the practice of physician-assisted suicide. See Steve Heilig et al., *Physician-Hastened Death: Advisory Guidelines for the San Francisco Bay Area from the Bay Area Network of Ethics Committees*, 166 W. J. MED. 370, 372-76 (1997). In order to clarify and facilitate meeting these guidelines, BANEC also provides sample forms including: 1) Physician Checklist in Assisted Death Cases, 2) Documentation of Offer of Consultation and Services by Hospice or Other Palliative Care Expert and 3) Informed Consent-Request for Physician-Assisted Death. See *id.* at 374-76.

Finally, for those cases where the granting of a request for physician-assisted suicide may be questionable or when the physician fears possible future liability, Dr. William J. Winslade, a recognized expert in medicine, psychiatry and behavior sciences, proposes that a formal prior review be available.<sup>245</sup> This formal prior review would provide a decision that is comparable to a judicial declaratory judgment finding that all the substantive requirements have been met. Therefore, the physician would be free from liability for granting the request for physician-assisted suicide.<sup>246</sup>

## B. POSTMORTEM REVIEW AND REPORTING

Reporting and monitoring is a necessary requirement for the legalized practice of physician-assisted suicide. Postmortem review of individual cases should be thoroughly conducted by state and/or regional physician-assisted suicide regulatory committees.<sup>247</sup> Such committees should be set up by state's medical board or association, made primarily of physicians who would be better qualified to review these medical cases.<sup>248</sup> The Washington State Medical Association (WSMA) End of Life Task Force states that monitoring should be a "joint responsibility of physicians, lawyers, legislators, and members of the general public."<sup>249</sup> There should also be a national regulatory committee that would be responsible for monitoring the state and/or regional regulatory committees. The function would not be to perform additional postmortem reviews of individual cases, but rather to monitor the statistics of requests and grants, and to respond to any complaints or suspicions of abuse. WSMA also proposes the need for

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Legalization of physician-assisted suicide would require that similar forms be developed and provided to all physicians and hospitals to ensure a consistent and neutral practice.

245. See Winslade, *supra* note 137, at 235-36.

246. See *id.* This may however, be met with opposition of claims of intrusiveness to privacy and autonomy which may be more appropriate for the courts to consider.

247. Review by the hospital who employs the physician assisting in their patient's suicide would be specifically excluded in order to minimize possibilities of biases and oversight. In certain states with a large number of requests for physician-assisted suicide, regional committees within that state may be more efficient.

248. There may be skepticism about physicians reviewing physicians, in that they would be lax in disciplining their colleagues. However, the President of the California Medical Board found physicians were more critical and imposed harsher disciplinary measures on their colleagues than non-physicians. Stuart Hseih, Lecture at the University of Southern California Law School, on Health Care Regulations (Jan. 20, 1998).

249. Peter McGough, Anthony L. Back & Jean Colley, *Physician-Assisted Suicide: Finding Common Ground*, 166 W. J. MED. 394, 395 (1997).

“periodic updates on the extent and practice of physician-assisted suicide [that] would provide a public accountability essential to maintain professional integrity.”<sup>250</sup>

Additionally, the cause of death reported in a death certificate should be the terminal illness that the patient suffers from, and not physician-assisted suicide or suicide. This will prevent obstacles in receiving insurance benefits or settling the patient’s estate. More importantly, it will ensure a patient’s right to privacy and confidentiality. Thus, it will be the physician’s responsibility to report the death to the appropriate regulatory committee.<sup>251</sup>

### C. PROHIBITIONS, SANCTIONS AND LIABILITIES

In addition to the guidelines mentioned above, specific prohibitions, sanctions and liabilities must be established in order to prevent a “market” for physician-assisted suicide and other possible abuses. For example, physicians and health care facilities should not advertise the practice of physician-assisted suicide.<sup>252</sup> If they do so, they should be reprimanded or prohibited from further practice. Regarding liability, stricter provisions, more than just a “good faith” compliance with the guidelines, are necessary to protect patients. Failure to meet these strict provisions, should lead to penalties and or a prohibition from further practice. The importance of liabilities and disciplinary measures of any statute are recognized, and in some ways they may even be more important here than the practice requirements and provisions. However, this area is beyond the scope of this Article, and may be better addressed by the American Medical Association in conjunction with legislators.

## V. CONCLUSION

Gender differences affect women and men from conception to the death. The gender differences that will have implications in MDEL include those of socialization and gender roles, suicidal behavior, depression and mental illness, life expectancy and illness, health care access and quality, and the physician- patient relationship. Unfortunately, these gender differences contribute to negative and disproportionate effects on women. This is exemplified in the practice

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250. *Id.*

251. BANEC also provides a sample form to clarify and implement the reporting requirements with the Report of a Physician-Assisted Death. See Heilig et al., *supra* note 244, at 377.

252. See Battin, *supra* note 148, at 147.

of physician-assisted suicide, due to under-protection and over-protection of women. Since physician-assisted suicide is currently being practiced in the United States, both legally<sup>253</sup> and illegally,<sup>254</sup> the time to recognize and regulate it is here. The best approach to minimize and prevent the effects of gender differences in the practice of physician-assisted suicide, is the recognition and regulation policy approach with a strict and detailed statute.

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253. See Death with Dignity Act, OR. REV. STAT. tit.13, ch. 127.800-127.995 (1997).

254. See Goodman, *supra* note 19, at A11 (referring to Dr. Kevorkian's practice); Buck Wargo, Donna Huffaker & Julie Marquis, *Hospital Worker Says He Killed Up to 50*, L.A. TIMES, Mar. 28, 1998, at A1 (reporting that a California respiratory therapist stated he killed as many as 50 seriously ill patients).